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Vol. XV, No. 5 | 1961 | September-October

TABLE *of* CONTENTS

ARTICLES

DIVISIONS

FEATURES

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HUDDLESTON'S
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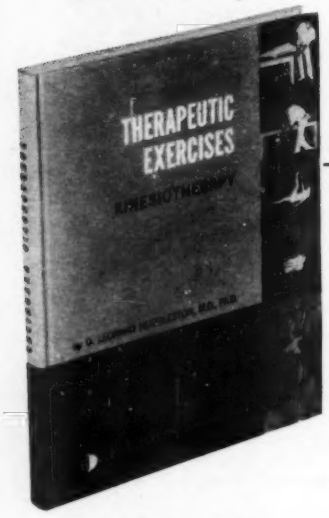
KINESIOTHERAPY



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CONTENTS

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Anatomic and Functional Consideration

Classification of Exercises

Administration of Therapeutic Exercise

Therapeutic Uses of Neuromuscular Re-Education and Manual Resistance Exercises

Complemental Therapeutic Exercises

Gait Training, Balance and Ambulation Exercises (Progressive Ambulation)

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EDITORIAL

INCREASED NEED

The Surgeon General of the Army, Lt. General Leonard D. Heaton, when he announced the increased requirement for qualified occupational therapists, stated that although limited, the need is urgent. He stressed that young occupational therapists can derive great benefit from the diversity of professional experiences available in the Army Medical Service.

Any list of leaders in the field of occupational therapy will include the names of many who once served with the Army. Among those who are numbered as former Army "OT's" are: Mrs. Winifred Kahmann, Miss Henrietta McNary, Miss Marie Louise Franciscus, Miss Marjorie Ball and Miss Barbara Jewett. Miss Helen Willard, our president, once served as an Army physical therapist while Miss Wilma West, our president-elect is still a member of the Army Medical Specialist Corps Reserve.

With the constant and complete coverage of national and international news, everyone is aware of the reason the United States is increasing its military strength. Everyone knows too, that many Reserve units are being called to active duty and can imagine the effect this may have on the plans of the men and women who serve our country as members of its Reserve forces.

In all the press coverage that has been given to these events, the terms "occupational therapy" and "occupational therapists" have never appeared. The average reader, knowledgeable though he may be, cannot share all aspects of your interest. He cannot be as aware as you are of the Army's increased need for medical personnel nor can he share your alertness to the certainty of the increased need for occupational therapists.

General Heaton's announcement can be no surprise. It should be a source of satisfaction. It is indicative of the important place occupational therapy has in the care of military patients.

The history of occupational therapists in the military service is one of distinction. They have always volunteered their services because they have obviously followed President Kennedy's philosophy. You will remember that in his inaugural address he said, "Ask not what your country can do for you—ask what you can do for your country."

General Heaton requests that occupational therapists, both men and women, who are interested and feel they can qualify for an appointment in the Army Medical Specialist Corps, write for further information. Your letter should be addresed to Lt. Colonel Cordelia Myers, AMSC, Chief, Occupational Therapist Section, Office of The Surgeon General, Department of the Army, Washington 25, D.C. She will be glad to answer questions any of you may have regarding this professional challenge and opportunity.

RUTH A. ROBINSON
Colonel, AMSC
Chief, Army Medical
Specialist Corps

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THE SOCIAL DETERMINANTS OF MENTAL ILLNESS AND PSYCHOSOMATIC DISEASE*

ELEONORA CHERNEWSKI, O.T.R., M.A.†

In working with the many types of patients referred to an occupational therapy clinic, we repeatedly encounter those individuals who seemingly have difficulty recovering from illness or who, once recovered from a prolonged affliction, promptly re-enter the hospital with another, and yet another; or who have remissions after an arrest of their indisposition.

The main objective of this paper is to survey the degrees to which personality, culture and status play a part in invalidism, psychological or somatic. Is the course of such illness psychologically, constitutionally or environmentally determined?

Every known society has faced the problem of disease, has consequently been obliged to develop methods for coping with it and has thereby evolved a medicine. In five basic concepts of world-wide distribution, disease is attributable to sorcery, breach of taboo, object intrusion, spirit intrusion and soul loss, as disclosed by currently available ethnographic material.

Primitive medicine has a large number of objectively effective factors in the form of a large pharmacopoeia along with surgery, baths, cauterization and the like, as well as psychotherapeutic methods which can be used to heal or to destroy. In primitive societies treatment is "not done in a rational sense, but in an entirely magical sense accompanied by spells or prayers or manual rites or dances."[1] Close interpersonal ties between primitive doctor and patient are furthermore reinforced by the frequent participation of the entire community in the treatment. Beyond this are the phenomena of broad restitutive movements such as the ghost dance and Peyote Cult in non-literate societies which might profitably be compared with Dianetics, Alcoholics Anonymous, Christian Science and other healing cults in modern society.

Medicine is a social activity for it involves interaction between two or more socially-conditioned human beings within a social system that defines the roles of the participants, specifies the kinds of behavior appropriate to each of those roles and provides the sets of values in terms of which the participants are motivated.

CULTURE

Medicine is a part of culture for it consists of a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals and symbols that interlock to form a mutually reinforcing and supporting system termed an "institution." Medicine as an institution is integrated with other major institutional complexes — government, religion, the family, art, the economy, education — into a functioning whole which is culture.[2]

Margaret Mead defines culture as an "abstraction from the body of learned behavior which a group of people, who share the same tradition, transmit entire to their children, and, in part, to adult immigrants who become members of the society. It covers not only the arts and sciences, religions and philosophies to which the word culture has historically applied, but also the system of technology, the political practices, the small inti-

*A paper presented to the department of psychology in partial fulfillment of the requirements for the master of arts degree in occcupational therapy, University of Southern California.

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mate habits of daily life, such as the way of preparing or eating food, or of hushing a child to sleep, as well as the method of electing a prime minister or changing the constitution."[3]

Culture is a complex whole with functionally interrelated parts; with historical continuity that transcends the time span of any given generation; with a determining influence in the way individuals come to perceive themselves and their relations to other people and to the nonhuman environment. Culture changes and can be changed; and because it is complex and its transmittal is inefficient, no individual quite acquires the whole of a culture. It is thus possible to distinguish, within cultural groups, sub-groups made up of persons who share traits that are uncommon to other members of the larger group. Physicians, because of their possession of special knowledge and skills, may be thought of as a subcultural group.

Within a culture operates a human society made up of both sexes and all ages comprising family systems; associations or groupings of individuals in such areas as trade, work, friendship and so forth; occupations associated with distinctions between male and female activities; and groups or individuals who are arranged in a graded "prestige series." Within these systems an individual occupies a status which may be ascribed or which may be acquired through competition, or lack thereof. It is the position of an individual in the prestige system of his society.

STATUS

Status entails the performance of overt aspects or patterns of culture transmission, together with the exercise of the covert elements of culture, that pose the values, points of view, attitudes, beliefs of an individual within a culture or subculture. His role covers the sum total of the culture patterns associated with a particular status and includes the attitudes, values and behavior ascribed by the society to any and all persons occupying this status. Role is learned on the basis of status and is therefore culturally defined. It is the dynamic aspect of status.[4]

Since human beings normally live as members of a society, there is found a pattern of organization throughout the whole range of social integrations. As itemized by Warner,[5] in our American society this pattern is contained within six groupings of social classes.

Because there can be no such thing as a completely static functioning culture, we have a continual process of mobility (social, geographic, technological) which obliges the individual to acculturate—to learn and accept new patterns of behavior, of value and of attitude. It is in this regard that the individual and society are aspects of one another.

The individual and his environment interact and create a field upon which the personality of the individual is moulded. A child is born into an atmosphere where at first things happen to him. Early in life he begins to learn certain concrete forms of behavior from instruction given him, as well as from his imitation of others. As he grows older he learns that certain behavior is rewarded and certain other behavior is punished. Thus patterns are established and conditioning takes place. A human being has an aggregate of biological, physiological and psychological needs to which his behavior patterns are responses. These developing behavior patterns are controlled by the social pressures within his culture to insure predictable habits in terms of the position he holds within the society. A favorable response from others is the reward for conformance and satisfies the universal need to be well regarded.

VALUES AND ATTITUDES

Ultimately the individual comes to live by habit, or rather a body of habits introjected and generalized, which make up the greater part of his personality and provide him with values and attitudes. The latter two components hold the emotional content of his responses.

Psychiatrists[6,7,8] and sociologists[9,10,5] have advanced the concept that an individual's movement in the social structure is a factor in the development of mental disorders. Empirical studies have suggested that psychological factors have an important bearing upon the origin of disease and upon the duration of symptoms.

A study of a series of acute head injuries disclosed that the individuals who were accident-prone and those who came from the lower social class status recovered speedily, while those who held middle-class status showed prolonged symptoms.[11]

The lower-class person has less repression about expressing anger, aggression and other impulse gratifications and is less bound by social restrictions. He thus is enabled to release his tensions by overt action. The middle class individual, on the other hand, meets with more dissatisfactions and frustrations of an inexpressible nature because of the value he sets upon conformance to beliefs and ideals. Therefore, for him, repressing becomes a defense mechanism and an escape into illness becomes the class-sanctioned solution. Furthermore, it puts his social climbing in abeyance for that, too, may be a neurotic manifestation and a source of great stress and strain.

Another factor in delayed recovery "may be conceived as a defense mechanism against an ambivalent situation which arises either simultaneously with the disease, or shortly before or after the patient falls ill."[12]

Those who harbor a number of persistent infantile conflicts in which they seek a parent substitute rather than a physician's scientific and objective advice tend to prolong their illness.

Parsons[13] advances the thesis that "illness, particularly psychosomatic or emotional illness, may be thought of as a special type of 'deviant' behavior — one of a set of alternatives which are open to the individual. The role of the sick person in our society is a sanctioned and institutionalized one, whereas the alternatives to illness may be participation in non-sanctioned deviant groups (the delinquent gang, the exotic religious sect) or in a life of social isolation (the solitary hobo, eccentric and criminal)." Such deviance was exemplified by the soldier's rheumatic, asthenic and gastro-intestinal complaints, by his low back pains or a "trick knee" and not because he was emotionally frightened or upset.

This pattern is suggested in studies done in three veterans' hospitals[14,15,16] which are thus summarized: "For many of these patients flight seems to represent an avenue of escape from situations which they perceive as intolerable. Others take flight to avoid punishment when they have failed to conform to the standards of society. Therefore, flight appears to be a two-way street for many of these patients who are constantly taking flight into the hospital from society, only to take flight from the hospital as soon as their wishes are frustrated."

Neurotic patterns characterized by a distinguishing theme or problem area were described in a three-generation family unit to point up the continuity of cultural change and the effect that long term group dynamics have on the genesis of pathology.[17]

SUMMARY

To summarize, this paper surveyed some of the literature pertinent to the areas of culture, personality and status viewed in the light of their influence upon psychological and somatic illness. Cultural factors in the acquisition and prolongation of illness were found to be social sanction, the prestige value and respectability of illness as a mode of retreat from the environment and the prestige of the physician in the culture. Personality factors were shown to suggest an inability on the part of the individual to express aggression, the individual's need for dependency and, in certain types of individuals, a special type of "deviant" behavior. Status was represented by the individual's social class and his social mobility: his ability to adapt and acculturate to new designs and to the tensions attendant thereto largely determined the type and duration of disease he would select to which to become subject.

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Development of Personal Integrity In the Patient With Chronic Illness

WILMA M. INSKIP, Ph.D.*

The patient who incurs a chronic illness, especially an illness that starts with an acute onset, has many problems to cope with that are taxing to the strongest ego. In this paper we will confine our attention to the problem related to illness in which there is obvious physical incapacity.

The sudden onset of an illness that leaves a person relatively helpless and incapacitated in comparison to his former level of activity results in what can only be thought of as a catastrophic reaction. It is probably impossible for any of us to fully appreciate the intensity of the emotional impact experienced by the patient who suddenly finds himself unable to carry on the business of everyday living. On the neurology service we have had patients try to explain their feelings to us. Essentially what they have tried to express is the despair originally experienced when it was apparent that they would no longer be able to return to their former level of physical activity and often not be able to return to their former way of life. Each has expressed in his own way the terrible loss of self-esteem and the fear that often approached panic which came when he realized he would be placed in a subordinate role when around able-bodied people. Each one felt the terror that came with knowing that he was dependent upon strangers for even the most basic kind of assistance such as eating, eliminating and keeping clean.

For many patients it was a matter of living in a world of constant threat, a world in which they were the aliens, for they could not believe that it was possible to communicate any longer with the people around them. Perhaps there is no blacker world to live in than one in which there is no friend to appreciate our feelings and no one who cares about our welfare. In such a world these patients begin to be plagued with mistrust of everyone around them; they start to bottle up feelings, especially of anger, because in such a threatening world if one should express anger it might lead to abandonment even of services grudgingly performed.

If such is the early despair following a catastrophic illness, then it must follow that the patient will also lose his purpose for living, whatever that may be. For the person with no self-esteem cannot have purpose or goals that are meaningful. It is at this stage of recovery that we are often first introduced to our patient. More often than not the referral will say that the patient is not motivated for therapy and he usually is not. If we recognize that the onset of illness has been sudden and has resulted in what is referred to above as a period of catastrophic reaction and despair, why should he be interested in our programs? He thinks of himself as nothing and he sees only years of nothing stretching ahead. How could such a person care whether or not his arm retains a full range of motion? Of what possible concern is it to him whether he talks so that others can understand? Why should he care whether he rides in a wheel chair or walks with a cane? At this particular moment he doesn't care.

CONCEPTS OF MOTIVATION

In dealing with these problems we have discovered that we have to change our own concepts of motivation. Out of our experiences on the neurology service it has become clear that we have been trapped by the old concepts of what constitutes man's drive to learn and attain goals. Like all sciences, psychology has been primarily concerned with the analysis of behavior during the past fifty years. We have spent much time in breaking down behavior into its parts and have essentially looked upon man as a bundle of reflexes and specific habit patterns. Unfortunately we have never quite come around to putting him together again in his essential humanness. We have too often overlooked an important principle suggested some time ago, that the whole is more than its individual parts. In our work the thing overlooked is that, unlike many of the animals used for the earlier experiments, man has a drive that is not classified with the essential biological drives. It is a need for mastery of the environment. Such a need for achievement must underlie what has been referred to as a purpose. Mastery of oneself and the environment can be used to stimulate interest in re-learning life skills in the same way that it must have stimulated such interest in the beginning. Out of the victory that mastery of one goal after another can bring grows more interest, more goals, more pride and self-esteem, and thus can emerge the integrated man instead of the despairing man.

*Staff psychologist, neurology service, Veterans Administration Hospital, Hines, Illinois.

How we may intervene and stimulate the disinterested or resistant patient is not a question of imposing motivation on someone as though we could force him to become motivated. It is a matter of creating a therapeutic environment in which the patient's inner resources have an opportunity to grow. In the first place, such an environment must provide for the person the kind of corrective emotional experience needed to re-establish his basic trust in others. It is important to help him begin to see that he is a worthy person and that it is possible that someone can understand how he feels. If he can believe that we, as human beings, have much in common in that we all experience the same kind of feelings, it is a step forward; for with the people who are concerned about one's welfare and do share important feelings, one can no longer be an alien in a strange world. From this kind of experience it is possible to take the next steps that will lead to re-learning skills, perhaps even developing skills not used before as a means of finding a place in the world and a position of respect in whatever community the patient will live in. This may mean the sheltered community of a hospital, the home, or a return to the larger community in some new capacity.

WHAT MAKES A GOOD THERAPIST

Whatever the goal of rehabilitation may be, it can take place only in the therapeutic environment provided by the therapists with whom the patient works. We have watched many therapists work in the past few years and have tried to figure out what makes a good therapist. We were interested because it became apparent that part of the intervention and stimulation involves the therapist and the interactions of that therapist and the patient. For some time we were puzzled by what it was that the successful therapists had in common, because they were certainly as different as night and day in their personalities and in the way they worked. One thing became apparent quickly and that was that the most outstanding therapists we observed were people who were creative and energetic. They could break with tradition when necessary and find extraordinary ways of stimulating a patient's interest. They found new ways of doing things or new assistive devices to make it possible for a patient to achieve a higher level of function. This, however, did not seem to be the essential answer, because other equally-creative people were not good therapists. I think it finally became clear to us what it is that these people have in common: They believe in what they do. They have a purpose in living. They have an enthusiasm about their work and about life. In their clinics there is a kind of joie d'vivre that does not exist anywhere else. It is this basic attitude that is communicated non-verbally to the patient. It says, "I believe in you," "I believe in myself," "I believe that if we pull together you can be helped," "I believe that the goals we set together can be accomplished." Thus hope is born and without hope it is doubtful that anyone will expend energy necessary to regain the many skills lost after a catastrophic illness or to maintain the skills he has retained or won back. Essential in a therapeutic environment is a therapist who possesses the basic attitude that he is a worthwhile person, a person who has a purpose he believes in and a job to do that he feels is important. With such belief, it is possible to believe in others, even the most damaged.

On the neurology service we believe that we can help the chronically ill and the aged achieve a higher level of personal integration through a well-planned rehabilitation program. We try to plan our goals and our program as realistically as possible. For some we hope only to achieve a degree of independence and social awareness necessary to optimal living in an institution; for others we work toward return to the family and community. Whatever the goal, we have made our choice and work toward it to the best of our ability. We do not believe that institutions or services for the chronically ill need be storage houses of despair. We do believe that they can profitably be treatment centers where each person has the opportunity to achieve his own optimal level of rehabilitation whether it be great or small.

You have kept me so busy I have forgotten why I am in the hospital.

Occupational Therapy and Social Group Work in the Home for the Sick Aged

A Comparison

LOUIS J. NOVICK, M.S.*

A birthday party is in progress at a certain institution. Working with the patients is an occupational therapist. Earlier that day, the therapist had been conducting an arts and crafts group. At another institution, another birthday party is in progress. Working with the patients is a social group worker. Earlier that day, the group worker too had been conducting an arts and crafts group. Both professions are involved with people in groups engaged in similar activities. Is it any wonder that confusion exists as to their respective roles?

WHAT IS A GROUP

This paper is an attempt to clarify the confusion. Since it exists however only insofar as the two professions engage in work with groups, it would seem well to understand first what a group is.

The eminent sociologist Earl Eubank defines a group as "two or more persons in a relationship of *psychic interation* whose relationship with one another may be abstracted and distinguished from their relationships with all others, so that they must be thought of as an entity."[1] Emory S. Bogardus defines a group as being "a number of persons who have some common loyalty and who participate in common activities and who are stimulating to each other . . . a social group consists of human beings in interstimulation."[2] Morton Deutsch states that, "a sociological group exists to the extent that the individuals or subparts composing it are pursuing . . . interdependent goals. A psychological group exists to the extent that the individuals composing it perceive themselves as pursuing . . . interdependent goals."[3] The first definition stresses the *interaction* of thought and feeling between members of a group; the second definition adds the element of the *common factors* around which this interaction takes place; and the third definition adds the element of *perception,* on the part of each member, of the interaction and common factors.

How does the group as defined bring benefit to the individual? Social scientists have discovered that the group helps the individual (1) to learn; (2) to satisfy his emotional needs; and (3) to have fun, relaxation and interesting times. The individual may learn facts, skills and work habits. He may learn to develop attitudes regarded by the group as proper and to accept values held by the group to be important. He may learn more about his own personality — the inevitable conflict within himself between the desire to be aggressive and the need to accept authority.

In the realm of the emotional life of the individual, he may be helped by the group to satisfy, among others, his need for self expression; for support in accepting difficult changes in his life situation; for belonging. Without a group, the individual would find it impossible to relax and have fun in such activities as parties, discussions, choral singing and the like.

DYNAMICS

What are the dynamics operating in the group through which the individual has his needs met? They are (1) an acceptance by others; (2) an interest in some activity or aspect of living which is common to all members of the group and may have to do with collecting stamps, knitting clothing for sick children, engaging in social affairs, raising money for charitable purposes; (3) participation with others in performing the common activity or setting goals and making decisions in relation to that activity.

When one is accepted by others in the group and, in addition, shares with them an interest in relation to which he participates, not only by concrete doing but also by setting goals and making decisions, he feels secure enough to look at his own personality objectively, thus seeing himself as others see him. He is motivated to absorb the group's attitudes and values by a sense of devotion to it and desire to retain its acceptance. He develops greater enthusiasm for learning the facts and skills connected with the common activity of the group, whatever that activity may be. He feels that he is wanted, loved and that he truly belongs. In addition, the group's achievements become his achievements too by identification. If the group helps others through charity or other means, he feels that he too has helped. He gains a sense of achievement, however, not only by identification with the group but also by what

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he, as an individual, does to further the group's aims. As he engages with the group in the common activity, he relaxes and has a sense of doing something interesting.

CRITERIA

It is significant to note that each dynamic is important not only as a factor in influencing the individual's capacity for learning and meeting his needs, but also as a factor in facilitating the capacity of the other dynamics to influence. When one is accepted, he participates more enthusiastically in the common interest. When one has an interest which is shared by others, mutual acceptance and participation are encouraged. When one participates in activity with others, enthusiasm for the activity is raised and the sense of mutual belonging heightened. All these dynamics, thus, form one interrelated complex.

There are certain other conditions, however, that enrich the soil within which these dynamics can operate. (1) *Democratic leadership* which encourages a free expression of thought and feeling. (2) *Organization* which is the assignment of clearly delineated responsibilities and units of work among members of the group and the definition of the manner in which communication among group members may take place. To the extent that organization is related to the needs of the situation, it encourages expression of feeling and thought and enables members to do their work properly and efficiently. (3) *Time.* In long-term groups, members have more opportunity to know each other, to follow common interests and participate with each other in their fulfillment. Furthermore, time allows for the development of proper forms of organization and democratic procedures. (4) *Size.* A small group enables members to know each other better and to participate with greater ease in common activities. It encourages free discussion and makes possible simpler and more effective organization. (5) *A skilled professional person,* who by his presence and activity encourages the operation of group dynamics and fosters the growth of conditions favorable to their operation.

What skills are required of the professional worker? He must have skill in forming a good relationship with the members of the group and controlling his own feelings and prejudices so that they do not blind him to the needs of the group. This requires a good deal of self-knowledge and awareness. He must help the group members to accept one another. This he does by accepting the individual member himself and by interpreting individuals to each other so that with greater understanding there develops greater acceptance. The other members, because of their respect for the worker and desire to please him, will be more inclined to accept the individual group member too. He helps the group release thoughts and feelings in discussion. In this way, common interests are expressed, needs discovered, program goals determined and decisions made. He aids the group to locate competent leadership within itself and gives information pertaining to resources which the group can use.

THE AGED RESIDENT

Having analyzed how the group benefits the individual, how and under what conditions it exerts its influence over him and how the professional person working with the group may expedite its potential as a helpful tool, let us now study the situation of the individual who lives in a home for the sick aged. Let us study what his needs are and how the group helps to meet them through the dynamics of acceptance, common interest and participation.

The aged resident of such a home tends to feel a loss of confidence in his own worth and ability. Part of this is due to the rejection that most old people, well or sick, suffer in an elder-rejecting society. Part of this is due to the association of the home with the poorhouse from which, historically, it developed. Even though people enter a home for the sick aged not because they are poor but because they need protective care, and even though the aged today receive income from government and other sources, the home resident, who is no longer able to hold a regular job, tends to feel that he is in the home because he has failed economically. In addition, the diminution of his self-image, caused by the encroachments of old age and sickness, acts further to decrease the resident's sense of self-confidence. Also, because his relatives frequently have assumed that he is no longer capable of doing things for himself, they have not permitted him to make his own decisions and guide his own destiny. When one considers all this, it is no wonder that the resident suffers a feeling of uselessness.

Because of the above factors, the resident of a home for the sick aged has developed needs which may be identified as follows: (1) the need to control his own living situation; (2) the need to earn some money for himself, to prove that he still has ability; (3) the need to help others since he is always receiving help from them; (4) the need to receive respect and recognition from others.

The home resident has usually lost his spouse and best friends through death. In addition, he tends to feel that his children have deserted him.

After all, there was a time historically when several generations lived under one roof. The fact that modern conditions do not permit this arrangement does not lessen the feeling of rejection. The resident, because of these factors, is usually desperately in need of friendship and a feeling of belonging.

The home holds many fears for the resident particularly before his admission. It is a symbol of death, the "last stop" for him. Furthermore, he fears that his every move will be dictated by others and that he will lose his identity as an individual. He needs very much to receive psychological support in adjusting to his new setting.

He is a living person and also needs the normal experience of fun, relaxation, new and interesting experiences. He needs this lift in particular because his pleasures, due to the ravages of age and sickness, have been considerably lessened.

He needs to regain as much strength as possible in muscles, joints and lungs weakened by disease and injury.

GROUP ACTIVITIES

What program of group activities has been established to meet all these needs? One form of group activity is the Residents' Club and its committees. The writer has observed the functioning of such clubs in several homes over a period of many years. The residents, in discussion, unfailingly express the following interests: (1) studying their daily living situation in order to find improvements; (2) fostering an atmosphere of friendship among all the residents; (3) planning various recreational activities.

RESIDENT'S CLUB

In order to follow these interests, they elect officers, establish committees and hold meetings of the total membership once or twice each month, at which time committee recommendations are brought forth, discussed and put to a vote. The officers consist of a president who also guides the meetings as chairman, a vice-president, secretary and treasurer. The committees consist of the executive committee, which acts between monthly meetings of the entire membership, as the planning arm of the club in matters pertaining to the home's administration of services, and in matters related to new program innovations; the sick-visiting committee which visits sick residents who are in the home's infirmary or in the nearby general hospital; the greeting committee which greets and orients new residents when they are first admitted; the newspaper committee which publishes the club newspaper, and the recreation committee which plans the content of various recreation programs for the total resident body.

What are some examples of work performed by the executive committee? The writer mentions the following from his experience: (1) The committee brought before the home administrator the problem created by having the lunch hour scheduled at 11:00 A.M. The residents had always insisted that a meat meal be served for lunch. Because Jewish custom dictates that six hours must elapse between the termination of a meat meal and the eating of dairy food, the lunch hour had to be fixed at 11:00 A.M. The residents then finished eating at 11:30 A.M. and ate their dairy supper at 5:30 P.M. Any advance of the lunch period to a later hour would have meant a proportionate advance of the supper hour too and a longer work day for the staff — a circumstance that was not possible. Because breakfast began at 8:00 A.M. and ended at 8:30 A.M., the residents had only a two and a half-hour break between breakfast and lunch. Their appetites were therefore poor at lunchtime. They could not enjoy their meals. Furthermore, they were deprived of important nourishment when they ate less.

The home administrator, in conjunction with the committee, suggested that the rabbis be called to study the possibility of granting a special dispensation which would enable the residents to eat at 12:00 P.M. and wait only five hours between their meat and dairy meals. This idea was brought first to the total club membership for approval. Upon approval, the rabbis were invited to meet with the entire club membership. They granted the dispensation which the entire group then voted to accept.

(2) The executive committee at another time advised the home administrator that the residents were dissatisfied with the bread, which they felt was too salty. The baker was invited to visit and speak with them. He agreed to separate from the general batch of batter an amount that would have a lesser quantity of salt mixed into it. This would then be used in baking bread exclusively for the residents of the home. At a subsequent meeting of the entire club, the residents voted that the bread was now much improved in taste.

(3) The executive committee recommended that the club be permitted to open a canteen in the home, with financing to be done by money from the club's treasury. They recommended too that a special account be opened in the local bank in which the club's dues would be deposited and that only officers designated by the club be empowered to draw checks against this account. Both recommendations were presented to the full club membership which discussed them and voted to accept them. Another recommendation of this committee passed by the club was that a specific percentage of all dues collected go to charity. Several charities, among them Red Cross, Cancer

Society and United Jewish Appeal were designated.

The sick-visiting committee and the greeting committee report to the entire club each month on their activities. The membership expresses considerable interest in these reports. It is obvious that they identify strongly with the residents helped by these committees. All of them have experienced being admitted into the home. Any one of them might become acutely sick at any time. During one report by the sick-visiting committee, somebody introduced the motion that when a resident died, it was important that a delegation of residents attend the funeral. It was also moved that the special prayer for the dead, usually recited daily by a son for an entire year following death, be recited by a resident, in instances where there was no surviving son. These motions were promptly approved.

The newspaper committee appoints one of its members as a reporter to gather news of interest for publication in the newspaper which is printed three times yearly. Who became a great grandmother for the fourth time? Who visited her son in Miami? Who celebrated her 100th birthday? Residents write articles. The committee as a whole edits the material which then goes to press. Constructive criticism is fostered at full club meetings.

The recreation committee plans all social events subject to club approval. These events include: birthday parties, live-music sessions, addresses by speakers, recorded music, bingo games, classes in English, picnics, bus rides, visits to points of interest.

VALUE OF ACTIVITIES

What needs do all these activities meet? When the executive committee and club members see that the home administrator not only listens to their complaints but accepts their recommendations for solving problems, they sense that they are being respected. They feel furthermore that they have a real measure of control over their living situation. When club members realize that they have full control over their treasury money, this gives them a sense of power and importance. When they can help others by giving charity, they find this a welcome relief from having only to accept help from others. When their name appears in print in the club newspaper, they experience again a sense of importance. Expressing an idea in committee which others accept and functioning as an officer offer more opportunities for recognition. Working together in committee to achieve the common goal creates a bond that unites the entire group. Achieving the goal gives each person on the committee a thrill of achievement. Not only committee members feel this bond of unity and this thrill of achievement. Members of the club who do not have the capacity to contribute too much in the way of thinking, feel that they too have contributed because they lent the weight of their vote to a motion. They feel that they are part of the club and take personal pride in its achievements.

This bond of belonging to each other is strengthened in particular by the mutual-help activities of the sick-visiting and greeting committees, and by the opportunity of enjoying good times together in the various social events. As the feeling of belonging deepens, as a new world of real rewarding activity opens up, residents lose their fear and anxiety in relation to living in the home. In the home they are not merely numbers. They are individuals, respected, capable of achievement. In the home they can live actively rather than merely wait to die.

It is important to note that the initial interests of the club members in the daily living situation are related closely to their need to control this situation. Their interest in fostering an atmosphere of friendship is related to their need to belong. Their interest in recreational activities is related to their need for fun, relaxation and being accepted by others. As interests are followed, needs are met. As needs are met, the concentration on the interests deepens. Interests and needs are inextricably intertwined.

SHELTERED WORKSHOP

Another type of group activity — in addition to the residents' club, its committees, and the programs they plan — is the sheltered workshop. In the workshop, the resident receives a salary for work supplied by business firms. The work must be of a simple nature so that even residents who are quite disabled can perform it. Usually a packaging job is involved. The dynamic which sparks the residents is the interest in earning money. Behind this interest is their need to prove that their ability is sufficiently good so that people are willing to pay money for it. The money they earn also gives them the power to buy what they need, contribute to some charity or give presents to grandchildren. An imaginative worker can find sufficient material around which the group is able to set goals and make decisions. They discuss such matters as the length of the work-day; the length of a break in the workday; the type of work which is best preferred; the rate of pay, i.e., should residents be paid on the basis of piecework or should there be one rate of pay so that the weaker member may benefit from the work of the more able. It is vital that the group members work together cooperatively because added to the desire for mutual acceptance is the need to produce well and according to specification, else the business firm will terminate its contract with the home.

ARTS AND CRAFTS

Still another type of group activity is the arts and crafts group. This activity may reflect many interests. Decorations may be necessary for a birthday party. The items produced in leather, clay, metal or wood may be sold, with the resident receiving a portion of the income for his work. The products may be sent as gifts to hospitalized children. If the art of cooking is involved, the cookies and cakes produced may be used for a picnic or for the very disabled residents who cannot get about without help. Again the interests reflect various needs: recognition of skill; conviction as to capacity to learn a new skill; giving to others; enjoying the companionship of people engaged in a similar interest. Here too an imaginative worker can draw the group into discussion around setting goals and making decisions so that through participation in discussion, the group's aim is better realized, achievement gained, self-confidence raised, common loyalties and friendships deepened.

PHYSICAL RECOVERY

In both the workshop and arts and crafts groups, a very valuable aim, which is physically therapeutic in nature, can be achieved. Where a resident suffers from an ailment brought on by disease or injury, the activity selected for him in the group can foster physical recovery by providing exercise designed to bring improvement to the affected part. Where the individual's interest in and need for physical recovery are bolstered by other interests and needs, associated simultaneously with the same activity, his enthusiasm for doing the necessary physical exercise is heightened and his physical recovery is speeded. Thus "two birds are killed with one stone." Of course, the worker leading a group whose members have need for physical recovery must have knowledge not only of personality structure and the dynamics of group interaction but great knowledge of the structure of the human body as well.

There is a group in the home for the sick aged which is distinguished from all others mentioned by one characteristic — the inability of its members, due to physical brain damage, to engage in intellectual inter-stimulation except on a very limited basis. These poeple can engage only in such activities as music, simple games and simple arts and crafts. There may be a degree of stimulation caused by the physical presence of the group and its activity. We could apply Deutsch's concept of the "sociological group" to this group. Its members do not have too great a perception of a common goal. In this kind of situation, knowledge of physical and intra-psychic factors is employed to a greater extent than is knowledge of group dynamics.

USE OF THE GROUP

Having considered the needs of home residents in need of protective care for the remainder of their lives, and how the group, helped by a professional worker, is used in meeting these needs, let us now proceed to examine what use the social group worker and occupational therapist may make of the group in the light of the stated aims of their respective professions. Harleigh B. Trecker states that social group work has a *dual aim.* With the help of the group worker, individuals use the group to "experience growth opportunities in accordance with their needs and capacities to the end of individual (and) group development."[4] By "growth opportunities" is meant opportunities to participate in various social activities, to participate in decision-making and goal-setting and to assume responsibility. These lead to "growth" or development in the individual toward a sense of achievement, of belonging and adjustment to others. By "group development" is meant the development of the group into an entity capable of operating independently along democratic lines. Such development is essential if a democratic society is to flourish. Since democratic leadership has already been stated to be one of the conditions essential to the maximal influencing of the individual by the group, it follows that such leadership is a casual factor in the proper development of the group as well as a goal which the group worker strives to help the group as a whole to achieve.

The aim of occupational therapy, as stated by Helen S. Willard and Clare S. Spackman, is "to aid a patient in recovery from disease or injury."[5] The disease may be either physical or mental. To achieve this aim, *"any activity"*[6] may be used, provided it is "medically prescribed" and "professionally guided."[7] This activity may take place with only the patient and therapist present, in which case a group is not involved. It may take place, too, within the context of a group in which case the two factors of activity and the group within which it takes place are used to achieve recovery.

The word "recovery" implies two things. (1) a prior *regression* to a lower level of physical or emotional functioning from which level (2) a *regrowth* is achieved toward the level of functioning enjoyed by the patient before the onset of his illness. We note, therefore, that both social group work and occupational therapy are concerned with helping the individual achieve growth in line with his needs and capacities. In the light of their stated aims and methods, therefore, both should use the group in every way possible as a tool for individual growth.

We recognize, however, that in a home for the sick aged the maximum regrowth or development that is possible in both the emotional and physical areas is limited by the irreversible damage suffered by the individual through disease and injury. Nevertheless, within the limitations imposed by this damage goals which are possible can be established.

DIFFERENCES IN THE TWO PROFESSIONS

What then are the differences between the two professions? The following may be listed: (1) Group work concerns itself with both sick and well individuals; witness the fact that institutions devoted to the care of the sick are adding group workers to their staffs. Occupational therapy is concerned only with helping the sick. However, when they both use the group for the purpose of emotional regrowth, as is the case with the residents of a home for the sick aged, their aim and their method is identical. (2) In practice however, the writer's experience with therapists and group workers indicates that the latter are more adept at the use of the group for the purpose of emotional regrowth than the former. One must search the literature of occupational therapy with much diligence for an analysis of what takes place in the process of group interaction, such as stated in this paper. At most, one will read that engaging with others in social activities such as dancing, parties or hobby clubs, in a warm friendly atmosphere, is stimulating and makes for "socialization." One does not read, however, about such things as the dynamic of participation through discussion in goal-setting and decision-making.

In this connection, the writer would like to recommend that the student occupational therapist be given more theory in the use of the group method and, in addition, receive more intensive training in its use in field work placement in homes and hospitals. (3) Group work establishes *group development* along democratic lines as a separate aim in itself in addition to individual growth. Occupational therapy establishes only the development or recovery *of the individual* as its aim. The development of the group along democratic lines is inextricably related to the development of the i n d i v i d u a l and to his needs as our analysis has shown. (4) One form of recovery which the occupational therapist helps his patient achieve is physical in nature. Physical recovery may involve a joint, a muscle or the lungs. The therapist is given a prescription by a doctor which directs him toward a goal of recovery involving the affected part. In order to select the proper therapeutic activity for each patient, in establishing the group, the therapist must have considerable knowledge of the human body. The group worker does not have physical recovery as an aim nor does he have the degree of knowledge necessary to achieve this aim. Hence where medical knowledge and knowledge of the group work method are both necessary, the occupational therapist is able to work with the group while the group worker cannot. In addition, it is preferable that occupational therapists work with groups when they are "sociological" rather than "psychological" in nature, i.e., where the degree of intellectual interaction can only be very slight. The group members here are deteriorated to a fairly large extent and the physical medical component is very pronounced. (5) What the occupational therapist does for his patients must be "medically prescribed." The group worker does not work under medical prescription. We recognize, however, that not everything that the therapist does requires a separate prescription. There are "standing orders," too, under which the therapist can operate with a good deal of independence. Such a standing order would be that the therapist do everything in his power to help the patient achieve psychological encouragement and benefit.

On the other hand, it would be well if group workers in homes conferred fairly often with the doctor to gain the best possible understanding of the resident's physical needs. The writer has seen group workers urging residents with very poor hearts to engage in strenuous dancing.

From our discussion thus far, it should be obvious that occupational therapy is not synonymous with "arts and crafts." The major interest of a group led by a group worker could be arts and crafts too. It should also be obvious that clubs, parties and outings are not the exclusive domain of the social group worker. In other words, the interests of the group or the "media," as they are referred to in occupational therapy, do not constitute a criteria of differentiation between the two professions.

In view of what has been said, what should be the policy of homes for the sick aged concerning the use of occupational therapists and social group workers? In answering this question, each home should try first to establish what the facts are in relation to the following areas: (1) How many residents have, in addition to their emotional needs, physical needs requiring the services of an occupational therapist? (2) How many residents do not have physical needs requiring the services of an occupational therapist and would therefore utilize the group only to satisfy their emotional needs? (3) Is the combined number of residents in both groups small enough so that one occupational therapist would be sufficient to work with them? (4) If more than one worker is nec-

(*Continued on Page* 211)

The Use of Psychological Tests to Predict Manual Abilities in Mentally Retarded Boys

ROGER REGER, M.A.*
ANTOINETTE DAWSON, O.T.R.†

In the Special Treatment Center at the Wayne County Training School the assumption is often made that a child's manual abilities in occupational therapy can be predicted from his Wechsler Intelligence Scale for children.[1] When a newcomer with a high performance quotient arrives in the unit it is assumed that he will be more skilled in the area of manual ability and coordination than if the quotient is low.

The Bender visual motor Gestalt Test[2] is often used for detecting the presence of brain injury and emotional disturbance. A system of scoring the test based on maturational level was devised by Keller.[3] Because the test requires eye-hand coordination it could be assumed that performance on the test might be related to performance in occupational therapy.

The purpose of the study reported here was to determine the relationship between performance quotient scores, Bender maturation level scores and rankings by an experienced occupational therapist on actual performance. The question was asked: What can the psychological test scores tell an occupational therapist?

SUBJECTS

The subjects were twenty-three emotionally disturbed, mentally retarded boys ranging in age from eleven to fifteen. They had been in residence in the Special Treatment Center at the Wayne County Training School from two to twenty-six months.

METHOD

With no advanced knowledge of what the project was about, the occupational therapist was asked to rank the boys with whom she had worked at least two months on a number of characteristics which have some relationship to functioning in occupational therapy. These included gross and fine motor skills, distractability, hyperactivity, degree of emotional control and tendencies to act impulsively and ability to learn new procedures. During the time these rankings were being made the Bender test was administered and scored. The Wechsler performance quotients were obtained from the records of the psychology department. It should be mentioned that the occupational therapist had spent at least one hour each day Monday through Friday with the group and so knew all the boys very well. In addition to rankings on actual performance the group was ranked according to age and length of residence in the Special Treatment Center. Rank order correlations were computed between the three areas ranked and statistical tests of significance were performed.[4]

RESULTS

Essentially, there did not appear to be a positive relationship between ranked test scores and rankings on actual performance. The correlation between Bender scores and Wechsler performance quotients was .68, which is significant at the .01 level of statistical confidence. (That is, the chances are only one out of a hundred that the result is accidental.) This suggests there is a positive relationship between the two psychological tests, and that within limits if the score on one were known the performance on the other could be predicted from it. The relationship between Wechsler scores and the therapist's ranking of "gross motor ability" reached the .10 level but this is not sufficient to assure that a better than chance relationship is involved. All remaining comparisons were not significantly related.

DISCUSSION

The question was asked, "What can the test scores tell?" Neither a positive nor a negative answer can be given to the question. Certainly, based on the results reported here it would be hazardous to predict a child's performance in manually related occupational therapy areas if only his Wechsler performance quotient were known. It would also be of questionable value to make a prediction based on results of the Bender Gestalt test.

It is felt that the value of this experiment lies in its erasing an assumption that may be held about the psychological test scores. There are many things that determine a child's performance in occupational therapy. His motivation is of utmost importance and this cannot be obtained from a score. His personal relationship with the therapist is also an unmeasurable but highly important factor.

(*Continued on Page* 221)

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Useful Adaptation Devices for Quadriplegics*

HELENA D. McBRIDE, O.T.R.
ERNEST BORS, M.D.

The literature is replete with references concerning self-help devices for the quadriplegic patient which enable him to accomplish activities of daily living. The adaptive equipment presented here, developed over a period of many years, was devised in order to meet the individual and variable requirements of each patient, considering the respective anatomical and functional deficit. Thus it was "tailor-made" rather than fabricated on a mass-production basis. It has stood the test of time in several hundreds of quadriplegic patients and has been found to be simple in construction and useful in its practical application.

One of the biggest advantages of this type of equipment has been that an occupational therapist, with some mechanical ability, has been able to easily construct these articles at a minimum of expense. In addition, the therapist has been able to work with the patient until he becomes proficient in the use of the articles.

Furthermore, it has been found at this spinal cord injury center, that these devices enable the patient to perform many tasks by himself for which he would have otherwise needed assistance. Therefore, the use of this equipment has saved many hours of nursing staff time.

Finally, the dual role of the occupational therapist as the teacher of the patient and as the constructor of these simple devices makes individual adjustment possible in each instance while therapy is in progress. This has the economic advantage that such changes can be made readily and inexpensively.

ADAPTATION FOR ZIPPO-TYPE CIGARETTE LIGHTER
Figures 1 and 2

Materials

Non-stretch leather, not over one and one-half ounce

One piece one and one-fourth by four inches

One or two pieces three-fourths by one and three-eighths inches

Four or eight Speedi-rivets

Three-thirty-seconds inch lacing, approximately sixteen inches

One or two "D" rings, seven-eighths, one or one and one-fourth inches

Glue ("Plyobond")

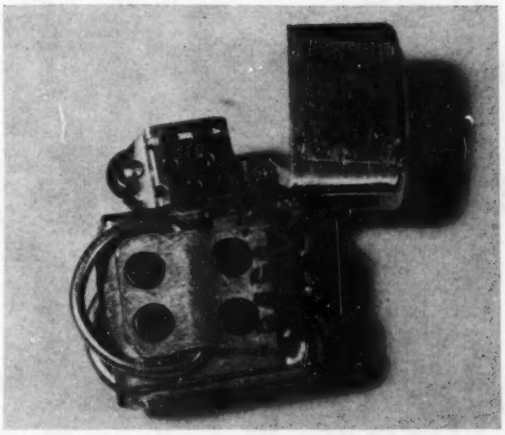

Figure 1

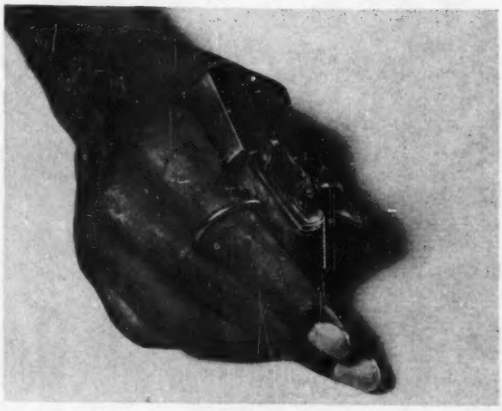

Figure 2

Instructions for determining placement of "D" rings

1. Determine if patient is able to use lighter with one "D" ring on thumb by placing adhesive tape across "D" ring onto lighter, of a size that will slip over the patient's thumb and have patient try it on. The ring is then riveted on the larger piece of leather, using small leather pieces cut in a width so that flat side of "D" ring is held snugly in place. The lacing may be at the

*From the physical medicine and rehabilitation service and the spinal cord injury service of the Veterans Administration Hospital, Long Beach, California, and the department of surgery, School of Medicine, University of California at Los Angeles.

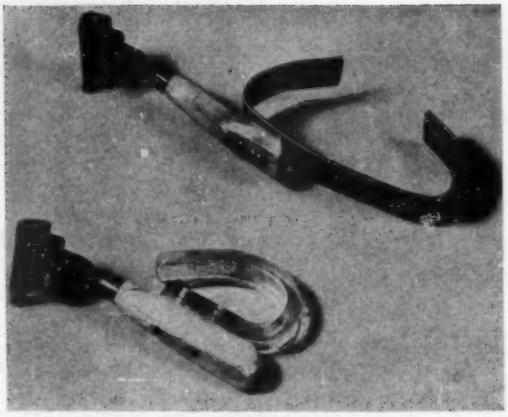

Figure 3

Figure 4

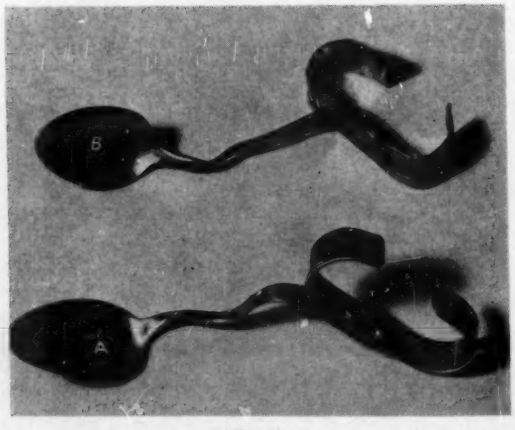

Figure 5

hinge end or on the opposite side from the "D" ring. About six holes are punched at both ends of the leather piece that will encircle the lighter and the lacing is inserted as in shoe laces. The lacing is left very loose so that after glue (Plyobond) is placed on both the lighter and the leather, it will be easy to slip the lighter in place. The lighter surface should be scratched before applying glue so glue will adhere better. Before putting the lighter and leather together make sure that the ring is on the proper side so that the hinge is at the patient's thumb web. When the lighter is in place the lacing is tightened evenly, using a modeler to pull on the strands, tied with a square knot, and the excess cut off. Wrap rubber bands around in all directions and let dry twenty-four hours before use.

2. If patient needs to use two "D" rings (determine as above) one is to be placed on the thumb and one is to be on the first finger. The "D" ring for the thumb is usually placed not over one-fourth inch from the hinge end and the "D" ring for the finger is about one-fourth inch from the front edge. The lacing is directly under the hinge. Assemble as above.

To light a cigarette

The lighter top is flipped open by placing the other hand at the front edge and moving the hands in opposite directions. The flint wheel may be rotated by the hypothenar eminence (under the little finger) of the opposite hand or it may be scratched on a hard corner surface.

Purpose

Patients with little or no grasping action in their hand may be able to use a cigarette lighter.

HOLDER FOR SHICK EJECTOR TYPE RAZOR

Figures 3 and 4

Materials

Schick type razor with solid handle

Two soft rivets

One inch metal band (.018 stainless steel) six and one-half to seven and one-half inches long or one-fourth by one-half by five inches plastic

Directions

Sand one side of razor handle so it is parallel to other side and drill two holes one-half inch apart near end to fit size of rivets. Drill two corresponding holes in metal band about two and one-half or three inches from one end. Rivet razor handle to metal band. Bend the band to fit patient's hand, being sure head of razor faces in opposite direction from bent part of hand piece.

Variation

Using plastic instead of metal band: One end of a one-fourth by one-half by five inches plastic piece is riveted near end of razor handle and

bent up and back along handle so it fits snugly over patient's first and second fingers between middle phalangeal and metacarpal joint.

Purpose

To provide a method for patient with no grasp to use a standard razor.

SPOON AND FORK ON METAL BANDS

Figures 5, 6 and 7

Materials

Two metal bands, seven-eighths, one or one and one-fourth inches wide, preferably .018 spring stainless steel about six and one-half to seven inches long, pre-bent along edges

Two soft rivets

One spoon

One fork

Directions

Flatten handle ends of spoon and fork in vise; drill two holes three-quarters of an inch apart near ends of handles to fit rivets. Before drilling holes in metal band, determine by having patient move hand from lap to mouth, whether he could use the utensils better with (A) thumb pointing toward midline of his body or (B) thumb pointing toward his head. Usually Model B is needed if patient has wrist drop. If Model A, band is riveted to top side of utensil handle. If Model B, band is riveted to bottom side of utensil handle.

Holes to match those in utensils are then drilled approximately in the middle of the band and the utensils riveted on the band. The band is then bent in a C shape so the patient can slip it from tip of fingers and over joints to thumb web. Spoon handle and spoon bowl are then bent in a usable position. A pair of brace shop bending irons or a portable vise and two crescent wrenches are used to do both types of bending.

Function

This device makes it possible for a patient with flaccid paralysis of the hand to feed himself. He needs coordinated motion in shoulder and elbows but little wrist action.

Figure 6

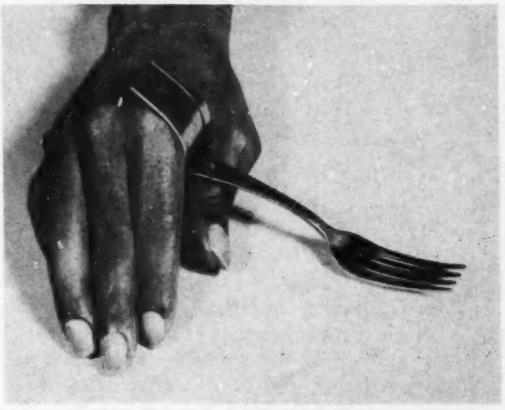

Figure 7

WRITING SPLINT, U-SHAPED PLASTIC

Figures 8 and 9

Materials

One-eighth inch plastic (Lucite, Royalite, etc), one by ten and one-half inches (For Type A, B, C or D)

One or two small, soft rivets

One Edwards No. 7615 "Security Clamp"

For Type C, an additional piece of one-eighth by three-fourths by two inches plastic

For Type D, an additional piece of one-eighth by three-fourths by six inches plastic, plastic cement, one or two extra rivets

Figure 8

Directions

Type A — arm and hand in a normal writing position — drill two holes of a size to accommodate rivet through one section of handle of clamp. Bend plastic to fit snugly on patient's hand between metacarpal joint and thumb with open end near little finger. Drill one hole of same diameter in center part of middle of already bent plastic. A patient must have good wrist stability to manipulate. Patient's fingers should not be flail but in extension.

Type B — arm and hand in neutral position on table — after plastic is bent in a U shape, a clamp is fastened on it one inch from center of the U. The open ends of the plastic are at the thumb side of the patient's hand. Little or no wrist stabilization is necessary. However, this neutral position is awkward, the hand tends to wobble and there are only two points of contact.

Figure 9

Type C — arm and hand in normal writing position — the additional piece of plastic should be long enough so that when it is riveted to the middle of the U, the other end will be about opposite the middle joint of the patient's first finger.

Two holes are drilled in the clamp but only one rivet is put in place so snugly that it takes some pressure to rotate it. Then the opposite end of the plastic is riveted at the middle of the U so that a second rivet can be put in if needed after patient has practiced and finds it necessary. This method makes it possible to change the position of the pencil or pen in relation to the hand as well as to change the angle of the clamp.

Type D — arm and hand in normal writing position, pencil protrudes between fingers — ask the patient to place his arm on the table in a normal writing position with his wrist cocked up. Measure the distance from his palm to the longest flail fingertip. This distance will determine how far away from the U-shaped plastic the clamp will be. Rivet the clamp near one end of the extra six inch piece of plastic. Then spot heat with alcohol lamp and bend the plastic at a right angle close to the clamp. Then, while holding the clamp, spot heat farther away (the predetermined distance between palm and fingertip) and twist the plastic 90 degrees. The clamp handles should be at the patient's thumb side so he can press on them with his other hand to remove or move the pencil. The other end of this piece of plastic will be glued to the flat part of the U-shaped plastic.

When plastic is cold, put a pencil in the clamp and a two inch piece of Scotch Tape across the flat end of the plastic. Put the U-shaped piece on the patient's hand and put the pencil between his fingers. Press on the Scotch Tape so pieces will stick together. Take the unit off the patient's hand carefully, glue together as marked, cut off excess, sand and buff.

To facilitate bending plastic, construct a series of molds made from balsa wood, each slightly wider than the other. Keep on hand the correspondingly marked U-shaped plastic hand pieces to try on for size.

Function

These devices make writing possible for a quadriplegic and will allow patient to put splint on and take it off at his own convenience. Constant daily practice from gross to fine motions (the Palmer method of writing) is mandatory to regain coordinated shoulder and elbow functions in relearning to write.

COMB OR TOOTHBRUSH WITH LEATHER STRAP ON DOWEL

Figures 10 and 11

Materials

Doweling one or one and one-fourth inch stock, five and one-half to seven inches long

Three-fourths inch leather strap, soft but not too stretchy, seventeen inches long

Toothbrush or rat-tailed comb, cut so teeth are about three and one-half inches from end.

Two three-quarter inch "D" rings

Speedi-rivet

Upholstery nail with large head

Plastic wood glue

Directions for comb

Using a drill slightly larger than the heaviest part of the comb handle, drill three or four holes side by side at one end of dowel, about two and one-half inches deep. Cut out material between holes so that you end up with an oblong hole. Taper this end of wood about one inch down dowel. Put two "D" rings at one end of strap with the Speedi-rivet to hold them. Cut a three-fourths inch slot in the center of the strap about three inches from "D" rings. Put the comb through this slot and then, using plastic wood glue, cement the comb in the wood. Put the dowel in the

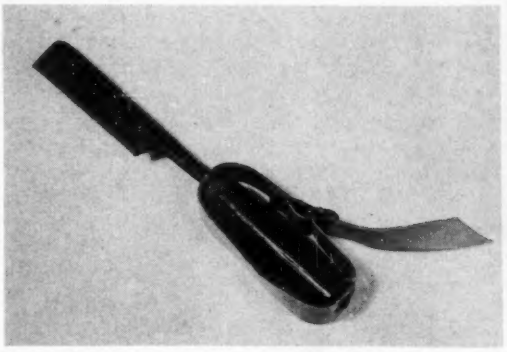

Figure 10

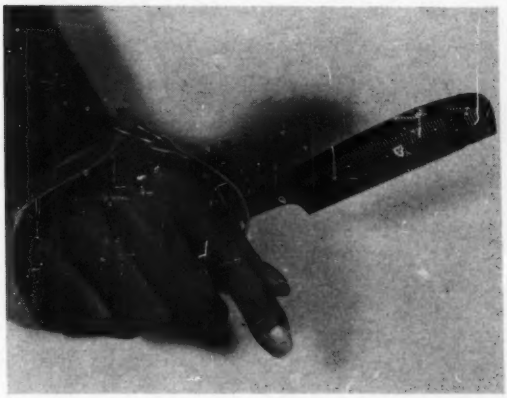

Figure 11

patient's hand so that one strap end falls on the outside of the thumb. The other strap end falls on the outside of the fingers. Take hold of the long end of the strap and put around bottom of dowel, making sure the comb is in center of the slot above. Mark where the strap hits the bottom of the dowel and, using this mark as the middle, make an elongated but thin slit about one and three-fourths inches long. Put the nail in the end of the dowel opposite the comb. The nail must be just tight enough so that the strap can move freely under the head of the nail. The patient will then be able to tighten down on the strap with his teeth. Make sure that the slits are long enough for straps to tighten on the hand. The strap is kept between the "D" ring at all times.

Directions for toothbrush

Use same method as above but do not glue toothbrush in oblong hole. Use a one-eighths inch wooden peg, driven through a hole in the dowel, to keep toothbrush in the handle. Then when it needs changing the peg can be driven out.

Function

To provide a means for a patient with no grasp to use a comb or toothbrush in a semi-swiveling manner.

She is not too enthusiastic about her rehabilitation, if you ask me.

Flexion Insert for Wheelchairs

ODON F. VON WERSSOWETZ, M.D., F.A.C.P.*
LINDA PARKER, O.T.R.†

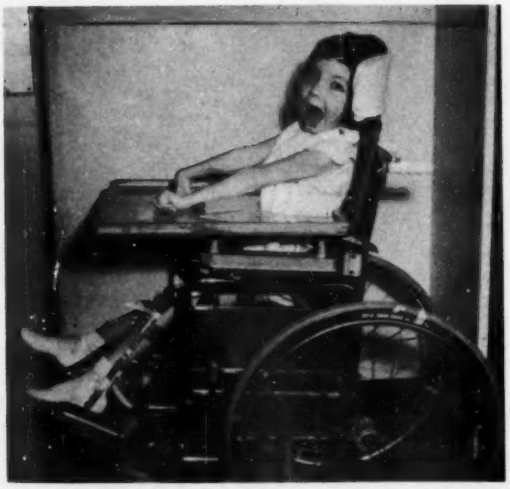

Figure 1

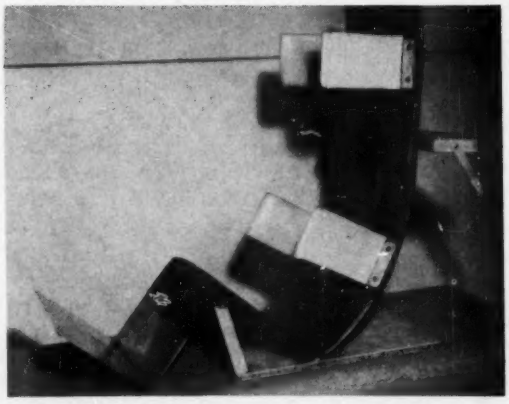

Figure 2

The flexion position is used to relax a cerebral palsy child who has a strong or excessive thrust (Fig. 1). This position can be obtained by various specifically made chairs and equipment which usually are hard to maneuver and often are too low for providing adequate care for the child. A flexion insert for a wheelchair was developed at this center for such patients (Fig. 2). This insert gives the child more control of the head and arms by inhibiting the extension pattern and has

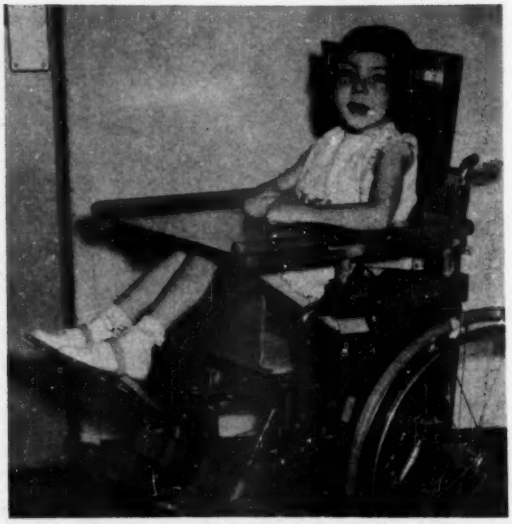

Figure 3

the additional asset of eliminating supplemental equipment such as straps, crotch posts, braces, etc., usually worn or attached to these children to force them to sit adequately.* Lateral supports may be needed on the insert for better postural alignment of the head, trunk or hips. For adequate placement of the feet and legs, shoe plates or foot straps are the only equipment added to the insert that are attached directly to the patient (Fig. 3).

The flexion insert is made of 24 ST Dural .064 metal which is shaped to the posterior contours of the body while in optimal controlled flexed position. The thigh support is straight instead of contoured and is angled sharply at the hips to keep the patient settled in one position so that he does not slide either up or down. This angle of bend at the junction of the back and thigh support is determined on an individual basis for each patient depending on the severity of involvement. The metal is attached at this bend to

*Medical director, Texas Rehabilitation Center, Gonzales, Texas.
†Occupational therapist, Texas Rehabilitation Center.

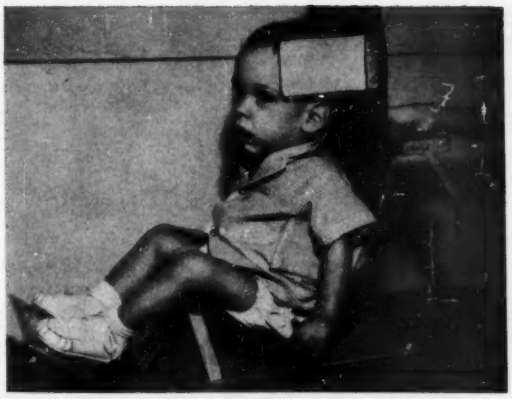

Figure 4

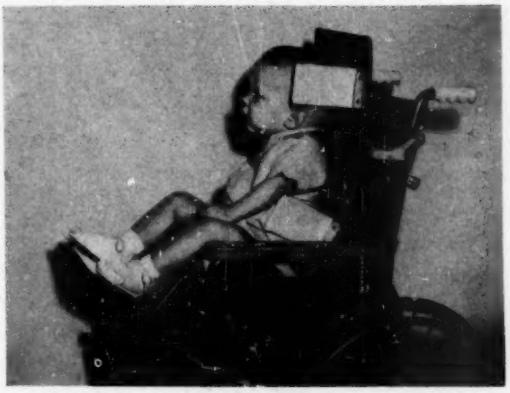

Figure 5

a board the size of the wheelchair seat and is padded with half-inch foam rubber and covered with naugalite.

Key control of the extensor thrust seems to be in the maintenance of some flexion of the whole spine (a smooth arc) and at least 90 degrees of hip flexion (Fig. 4). Occasionally a padding for the nape of the neck is necessary to provide better relaxation.

The advantage of this insert is that it can be tilted to the right angle so that the child can see ahead (Fig. 5). It is also much easier to manage and is portable because the insert can be removed easily and the wheelchair folded for transportation.

*The straps seen in the pictures of patients in wheelchairs are safety belts used on all patients to prevent accidental falls when the lapboard is removed. The strap does not hold the hips down as they are applied loosely.

OT and Social Group Work . . .

(*Continued from Page 203*)

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The writer has had the experience of supervising an occupational therapist in the more effective use of the group in meeting the emotional needs of residents, with fine results. Experience in either event has shown that both professions have made important contributions to the welfare of residents in homes for the sick aged.

REFERENCES

1. Earl Eubank, "The Concepts of Sociology." (Boston: Heath, 1932) P: 163.
2. Emory S. Borgadus, "Sociology." (New York: Macmillan, 1949) P: 4.
3. Morton Deutsch, "A Theory of Cooperation and Competition," Human Relations; Vol. 2, No. 2, 1949, P: 160.
4. See Harleigh B. Trecker, "Social Group Work." (New York, Whiteside Inc. 1955) P: 7.
5. Helen S. Willard and Clare S. Spackman, "Occupational Therapy" (London: J. P. Lippincott & Co. 1947) P. 10.
6. Ibid.
7. Ibid.

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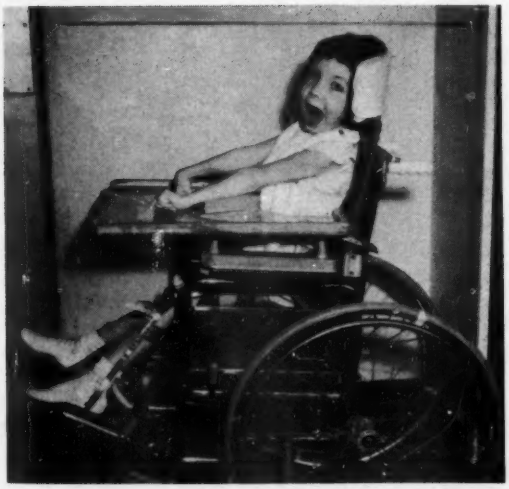

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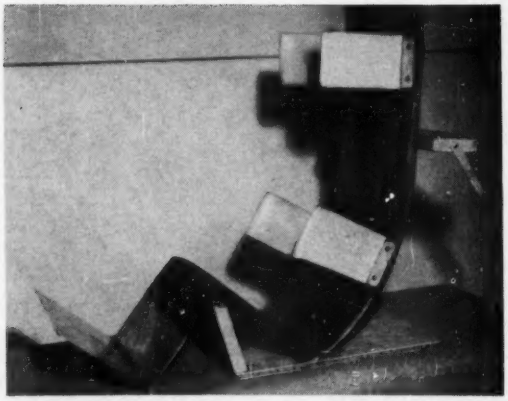

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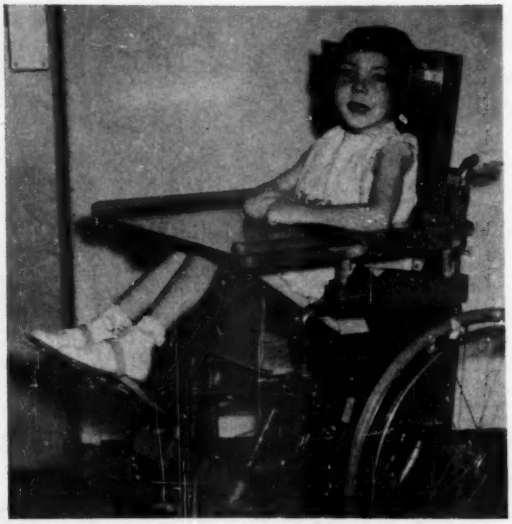

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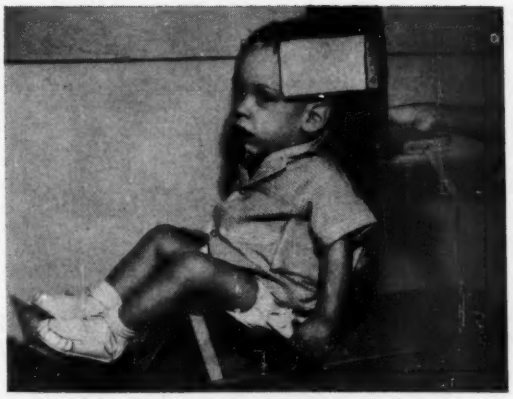
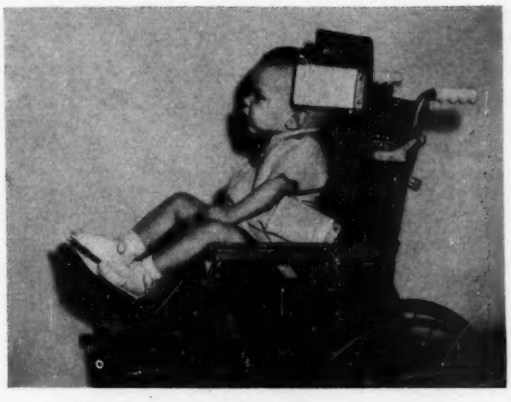


Figure 4



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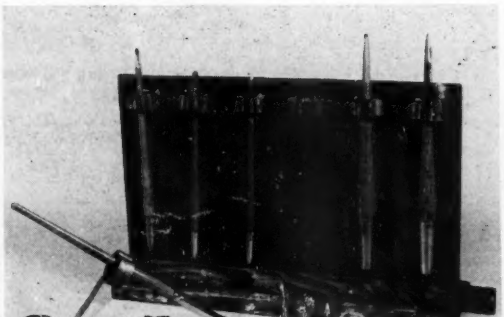
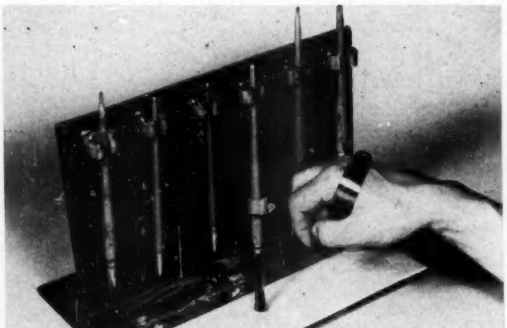
A Stencil Brush Holder

PATRICIA F. BROWN, O.T.R.*



Brush rack holding brushes. Hand attachment holding brush ready for use.



Patient with limited hand function using hand attachment to release brush from brush rack.

DEVICE

Brush rack for holding stencil brushes incorporated with a brush holding hand attachment for use by patient with limited use of hand function.

DESCRIPTION

The brush holding rack consists of a vertical stand constructed of one-fourth inch plywood approximately twelve inches long by eight inches high with a wooden base for stability. The base measures approximately twelve inches by eighteen inches of one-fourth inch plywood. The standing part employs six steel broom clips attached approximately one inch below the top to hold six stencil brushes in vertical position. It is attached to a base by butt blocks or strips, nailed or screwed to the base piece in such a manner that the vertical part fits snugly into a slot and is removable for ease of storage.

Brushes are held vertically at the top by broom clips and at the bottom by a one-fourth inch by one inch wooden strip twelve inches long, held in position by wide brads closely nailed to either side of it and about one inch from the base of the vertical part of the rack. This piece is also removable for cleaning. It holds the bottom part of the brush in position so that it can be either inserted or removed with the hand device.

Located on the front of the base is a cardboard or plastic piece twelve inches long. It is held in position by masking tape and has a removable cover of wax paper to hold all necessary paints for ready use.

HAND ATTACHMENTS

The hand attachment consists of a stainless steel band open at one end to permit size adjustments. A four inch extension is riveted at right angles to the middle of the band. A broom clip is riveted to the extreme end of this extension in such fashion that the brush, when attached to this clip, is held at a right angle.

APPLICATION

This device allows the patient with limited use of finger function to mechanically grasp and hold and release the various brushes as they are needed by pressing the spring type broom clip against the brush handles.

SUMMARY

This device is simply constructed and easily cleaned because of its removable parts. It also allows easy access of the necessary brushes and holds them ready for use in an orderly fashion. The colors can be mixed by the patient who can function independently with a minimum of assistance from the therapist.

*Staff occupational therapist, physical medicine and rehabilitation service, West Roxbury Division, Consolidated VA Hospital, West Roxbury, Massachusetts.

NATIONALLY SPEAKING

From the President

This is the last time that I, as your president, shall have the opportunity of talking to you all. These last three years have been eventful ones in the history of our Association. Never, I believe, have so many of our members been so deeply involved in our national affairs. Our membership is better informed, has an increased sense of responsibility and is more actively interested in the problems and procedures of our organization than ever before.

Like almost all of our fellow organizations we have been carrying on a critical analysis of ourselves trying to define our role accurately, to discover both our strengths and weaknesses, to develop one and correct the other. This is a healthy procedure and on the basis of honest recognition of our faults we should be able to do much toward better understanding ourselves and better interpreting to others the exact part which occupational therapy plays in rehabilitation.

The report of the development advisory committee, which will be presented this fall should be of very great value in charting our future course. Of even greater importance will be the results of the curriculum survey. The program instituted under the grant from the National Foundation has progressed slowly with many difficulties and unpredictable and unavoidable vicissitudes. Now it is nearing completion and should soon provide us with much food for thought and reason for many possible changes.

We are aware of the fact that we still have very far to go in developing occupational therapy to its fullest potentialities. We ourselves have by no means yet recognized the actual depth and scope of our work. It is only about fifteen years since the first opportunities for masters degrees were made available in our own field and real study of our procedures began. We still have a mere trickle of such degrees whereas we should have a full river. I do not mean to be derogatory of what has been accomplished in this respect but I do urge that we increase our efforts, seek opportunities for study and research and raise ourselves to true professional stature which will command the respect of all those members of other medical groups with whom we work.

I am heartily in accord with the recommendation made by the graduate study committee in Akron last spring that we develop four year B.S. degree courses followed by master's degree programs which will more completely prepare the occupational therapist to guide and direct the use of varied activities in the treatment of the patients. There is great need for better analysis of the effect of activities both from the point of view of their intrinsic characteristics and the results that may be achieved by more accurate knowledge of their application to specific conditions.

We should build soundly and insist on high standards but, I believe, that, as a group, we have a tendency to be too cautious and too slow to experiment and to act. We have matured greatly over the years but there is still great room for growth and development. We should not fear or resist change and should welcome eagerly constructive criticism.

If we are to achieve our full stature we must develop both our clinical departments and our school programs to the greatest possible degree. In order to do this we must educate everyone with whom we come in contact in the proper use of occupational therapy. We must select our future occupational therapists with the greatest care so that they may not be craftsmen but medical specialists who have an important and clearly defined function.

Public education and recruitment are therefore, to my mind, of the utmost importance. Everyone of us should be convinced that it is our individual responsibility to express our aims and purpose as clearly and graphically as possible and to study and practice how best to do this. Everyone of us should seek opportunities to tell young men and women of the challenge which exists in our profession and to interest them in preparation for work in this field. Only by time and sincere dedication to the needs and development of our education and practice can we continue to grow.

It has been an exciting experience to serve as your president. I have deeply appreciated the confidence which you have placed in me and have tried to serve you as wisely as possible. To all of you from the members of the Board and state association, the House of Delegates, the many chairmen and members of committees, who have worked so tirelessly, to every member of our Association go my thanks and my good wishes for your success in all your endeavors.

We find much to criticize in ourselves but when we look back over the years of our development we can be proud of the record we have made and the progress achieved. May we continue to grow in strength and knowledge in helping those disabled, handicapped and underprivileged persons who need our services.

Helen S. Willard
President

United Cerebral Palsy Research & Educational Foundation, Inc.

Scholarship Fund for Undergraduate Occupational Therapy Students

Academic Year 1960-61

The United Cerebral Palsy Research and Educational Foundation, Inc., again granted $10,000 for scholarships for undergraduate occupational therapy students for the academic year 1960-61. Twenty-eight colleges or universities offering approved curriculums each received the equivalent of 53.9% of one year's average tuition costs for one student. This amount, in some instances, was awarded to one student only and, in other cases, was divided among two or more students. The initial screening of applications was the responsibility of each college or university scholarship committee and the director of occupational therapy at that institution. In this way, recipients were selected by those in a position to know best the potentialities and needs of the applicants. Applications were then sent to the American Occupational Therapy Association for final approval and forwarded to the United Cerebral Palsy Foundation. Awards from this fund were for tuition fees only.

1. Number of institutions participating 28
2. Number of applications processed 188
3. Number of grantees 45
4. Home states of grantees 22 + Pureto Rico
5. Grantees' academic year
   a. Junior 27
   b. Senior 9
   c. Senior and Clinical Affiliation 3
   d. Post-degree (Advanced Standing) 1
   e. Clinical Affiliation only 5
6. Range of scholarship awards ..... $17.00—$693.00
7. Total amount awarded to 45 grantees $9,348.00
8. Administrative costs paid to AOTA ..... $ 400.00
9. Total disbursement $9,748.00
10. Final balance on $10,041* grant, June 1961 ..... $ 293.00

*41.00 balance carried forward from 1959-60.

Since 1954, $75,000 has been received from the Foundation for undergraduate scholarships and an additional $10,000 grant for the academic year 1961-62 has been announced. In behalf of the entire membership of the American Occupational Therapy Association, sincere appreciation is expressed to the United Cerebral Palsy Research and Educational Foundation, Inc. for the continuing and generous support of the professional education of occupational therapists.

COMING EVENTS . . .

Annual meeting of the American Heart Association. Americana Hotel, Miami Beach, Florida, October 20-22, 1961.

* * *

Conference of the American Occupational Therapy Association. Sheraton-Cadillac Hotel, Detroit, Michigan, November 2-10, 1961.

Symposium on speech handicaps of the cerebral palsy patient at the convention of the American Speech and Hearing Association. Hotel Sherman, Chicago, Illinois, November 7, 1961.

* * *

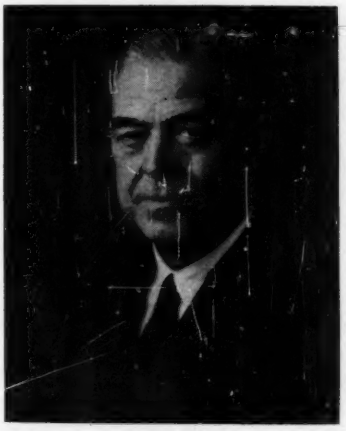
Annual convention of the National Society for Crippled Children and Adults. Denver-Hilton Hotel, Denver, Colorado, November 17-21, 1961.

Forty-Fourth Annual Conference

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

November 2 to 8, 1961
Sheraton-Cadillac Hotel
Detroit, Michigan

Conference Personalities



Theodore O. Yntema, Ph.D.

The featured speaker at breakfast on Monday morning will be Mr. Theodore O. Yntema, chairman of the finance committee and director and vice-president of the Ford Motor Company, who will offer his views on the "Highest Common Factors in Occupational Education."

He holds a master of arts in chemistry from the University of Illinois, a master of arts in business and a Ph.D. in economics from the University of Chicago, with further study in economics at Harvard.

Prior to joining the Ford Motor Company in 1949, Mr. Yntema was professor of statistics, business, and economic policy at the University of Chicago, where he began teaching in 1923. Between 1942 and 1949 he served as research director of the committee for economic development.

Mr. Yntema, a native Michigander, is a trustee of the Michigan Colleges Foundation, the Cranbrook Institute of Science, and the Cranbrook Academy of Art.

Thelma Gray James, M.A.

Professor Thelma James has been a member of the Wayne State University department of English since 1923. In two of her well-known courses she makes the Bible live as literature and she whets the appetite of curiosity and interest about folklore. She is nationally known in this field and has been president of both the Michigan Folklore Society and the American Folklore Society.

She received her master of arts degree from the University of Michigan and has studied at the University of Chicago. A Phi Beta Kappa, she was instrumental in establishing Wayne State University's Chapter.

Among honors accorded to her are those of being one of Detroit's "Women of Distinction" and of being the official guest of the West German Federal Government in 1959.

A dynamic and fascinating speaker, she will talk on "Reading, Thinking and Healing" at our Tuesday night banquet.

Mary Reilly, Ed.D.

Mary Reilly, Ed.D., O.T.R., the Eleanor Clarke Slagle lecturer for 1961, has been a practicing therapist since 1940. As a civilian, she filled the position of chief of occupational therapy at Fort Devens, Massachusetts, Walter Reed Army Medical Center in Washington, D.C., and Letterman Army Hospital, San Francisco. From 1947-1950 she served as assistant chief in the Office of the Surgeon General. She has been a consultant for the Army Hospital, Southeastern United States, Tuft's University School of Occupational Therapy, council of school directors of the American Physical Therapy Association and the Neuropsychiatric Institute, University of California. She has been on the teaching staff of both the University of Southern California and University of California at Los Angeles. At present she is the director of occupational therapy and assistant professor at the University of California Medical Center.

She is the current president of the Southern California Occupational Therapy Association and a member of AOTA Board of Management. She has served in the past on the National Council for Research, the Baruch Committee of Physical Medicine and the interview board of the Fullbright Committee for International Awards. Her own awards include ones from the Edinburgh Film Festival and the American Medical Association for occupational therapy films, and the Army Meritorious Service Award.

She is the author of several articles which have been published in AJOT, OT & R and other periodicals.

Focusing on the responsibilities implied in the "occupational" part of our professional title, the theme of her presentation is entitled "Occupational Therapy Can Be One of the Great Ideas of the 20th Century."

Colonel Ruth A. Robinson

Colonel Ruth A. Robinson, chief of the Army Medical Specialists Corps since November, 1958, is known to all occupational therapists for her professional and personal attributes. She is a former president, vice-president, and member of the Board of Management of the American Occupational Therapy Association. In 1959 she received the Award of Merit of this association for her many contributions to the profession and its practitioners.

Colonel Robinson graduated from the Boston School of Occupational Therapy in 1939 and was employed by the Community Workshops, Boston. From February, 1944, until May, 1948, she served as an occupational therapist with the Medical Department of the Army in a civilian capacity. During this time she was chief occupational therapist at England General Hospital in Atlantic City, New Jersey, and later served as consultant in occupational therapy to the Surgeon, Headquarters, Second Service Command. After World War II, she served as chief occupational therapist at Brooke Army Hospital, Fort Sam Houston, Texas.

In May, 1948, she was appointed as captain in the Women's Medical Specialist Corps, Regular Army, and in August of that year was made chief of the occupational therapy section of the Corps and promoted to the temporary grade of lieutenant colonel. She served in this capacity until June, 1952, when she was assigned as chief ocupational therapist, Fitzsimons Army Hospital, Denver, Colorado. Prior to assuming her present office, she was chief, occupational therapy section, Walter Reed Army Hospital.

Eminently qualified for her topic, she will speak on "Directional Signals for Professional Growth."

William N. Hubbard, Jr., M.D.

Aloysius S. Church, M.D.

Dr. William Neill Hubbard, Jr., dean of the Medical School and associate professor of internal medicine at the University of Michigan, Ann Arbor, will discuss "The Role of the Patient in Interprofessional Relations." Since most therapists have a preconceived notion of the patient's role we should find this an interesting and timely subject.

Dr. Hubbard come to the University of Michigan in July, 1959, from New York University where he had served as assistant professor of medicine as well as assistant and associate dean of the College of Medicine. He attended Columbia University, the University of North Carolina School of Medicine and received his doctor of medicine degree from New York University College of Medicine in 1944. He has held numerous faculty appointments and maintains membership in multiple medical, civic and honorary societies.

"Basic Attitudes for Occupational Therapists" will be discussed by Dr. Aloysius S. Church on Wednesday afternoon, November 8th. He received his medical degree from Wayne University College of Medicine and Surgery in 1937. His past experience includes positions as consultant with the Youth Service Bureau (wayward girl problems) and the Catholic Family Center (marital problems) of Detroit and as medical director of Lincoln Hall for problem boys in New York.

As assistant medical director of St. Joseph's Retreat in Dearborn, consultant psychiatrist with the Detroit Public School System, and consultant at the Sarah Fisher Home in Farmington, Michigan, Dr. Church has many opportunities to observe occupational therapists and formulate some "basic attitudes" for them.

The preliminary program for the AOTA annual conference November 2 to 8 was published in the August issue of the *American Journal of Occupational Therapy*. Preliminary meetings are scheduled from Thursday, November 2 until Sunday, November 5. The conference program will begin on Monday, November 6 and end Wednesday evening, November 8. Local occupational therapy departments will be open for visits on Thursday and Friday, November 9 and 10.

This new schedule, condensed for efficiency, will enable attendance of those occupational therapists unable to attend long sessions. The three days will be packed with interesting and constructive sessions and the last two days of tours will enable members to visit more departments than ever previously scheduled in a conference program. Therefore plan to attend the meetings in Detroit. You will gain contacts, inspiration and knowledge.

World Federation of Occupational Therapists

FOURTEENTH WORLD HEALTH ASSEMBLY

Report of the Delegates

The Vigyan Bavhan, New Delhi, India
February 7-24, 1961

Part I

The assembly of the fourteenth World Health organization was declared open at 10 a.m. on Tuesday, February 7, 1961, by Dr. H. Turbott, president of the thirteenth assembly, in the presence of the prime minister of India, the Honourable Mr. Jawaharlal Nehru, and other distinguished guests.

Mr. Kamarkar, the minister of health of India, extended a welcome to all present on behalf of the government of India, and noted that the occasion was of a certain particular signiñcance in that it was the first assembly to be held in Asia. He recalled that India had been one of the first to welcome the formation of the World Health Organization, and one of the first regional organizations to be established was that of South East Asia, in 1948. From its inception WHO had not only maintained the role of a guiding agency for the health and welfare of the world but had also succeeded in solving some of the most difficult problems in the field of health.

Dr. Turbott emphasized the Organization's appreciation of the immensity of India's problems and its desire to assist her people in the shortest possible time to higher standards of health, and he paid tribute to the progress already achieved.

In reviewing the work of the organization during the past year Dr. Turbott stressed the need for the WHO member countries who "have" to encourage international measures, e.g. financial, agricultural and cultural, aimed at stimulating the social progress and better standards of living in members who "have-not."

Mr. Nehru spoke of the impressvie achievements of WHO, and in particular of its success in avoiding the controversies and conflicts that afflicted some other world organizations. For the first time in history, the world as a whole possessed the means to solve its primary problems of the welfare of populations—food, clothing, housing, health and education. But even now the means were not always used to the best effect, which engendered a feeling of frustration. In the vital task of promoting a spirit of cooperation the approach of WHO was more progressive; it was engaged not only in the important task of spreading health but also in the even more important task of creating an atmosphere which could be conducive to the mental health of the general community.

India, in the 13 years since independence, had had overwhelming problems which were being dealt with, with a measure of success, but bigger and more difficult problems rose to be faced. That was, however, a measure of success as it was only those peoples or those communities that were stagnant that had no problems before them.

The most serious division that afflicted the world was that between developed affluent societies and less developed countries. It brought all kinds of political, social and other dangers in its train. The two groups faced different sets of problems, and the mutual aid which alone could solve them was menaced and tended to get lost in differences of approach which threatened the political and social health of the whole world community.

Mr. Nehru was glad that WHO has so many new members from Africa. The health of that vital, dynamic continent was of vital importance to the health of the world, and he considered that all countries that were more favorably circumstanced should offer help as far as they could.

Part II

In presenting a summary of the discussions and decisions reached at the fourteenth World Health assembly, it should be remembered that the overall aim of WHO is to improve the health of all peoples.

This international organization does not itself directly control or undertake health work in member countries but it works with national health services, and assistance is given to countries on requests from their governments. The national health authorities carry out field programs for which international assistance is given. The two principal ways in which WHO assists countries are by granting fellowships for study abroad or by sending specialists or teams of health workers to the member country.

The main purposes of the assembly are to review and examine the work that has been carried out in the different countries and to plan future work both in the traditional and the new fields in which WHO's help is requested.

Dr. A. L. Mudaliar (India) in his presidential address stated "Great as has been the work of WHO during the past 13 years, considerable as have been its achievements, significant as has been its effect on the reduction of morbidity and mortality in most lands, no one can deny that WHO has yet a greater part to play. It cannot afford to rest on its laurels, there are still many diseases which require its constant attention and intensified activity.

"Yet as disease after disease is being controlled, the problems of world health are becoming increasingly complex. New diseases have unfortunately come to light and some diseases have become much more common than before. As new discoveries are made and new remedies are placed in the hands of the medical profession, one has to realize that the goal of public health work in respect to most diseases which affect the masses of the people will be more of prevention than ever and that control and eradication are measures which must be thought of only when the disease actually sets in."

Assistance to the Republic of the Congo. The most noteworthy activity of WHO in 1960 was the help given to the Republic of the Congo to enable it to meet the emergency that occurred after the attainment of independence. The way in which WHO responded to this challenge is one of the best proofs of the soundness of its structure and of the maturity it has reached. This emergency assistance was provided at the request of the Security Council in accordance with the agreement between the United Nations and the World Health Organization.

Within a week, 28 members of the staff of WHO were in the country and 25 Red Cross Organizations had provided 28 medical teams to work there. The director general reported that at the request of the government of

the Congo, a group of 130 doctors and technicians were now being engaged by WHO to work there and that these temporary engagements would soon be increased from 400 to 500. In order to meet long term needs, the University of Leopoldville had been asked to enlarge its medical school and WHO had offered fellowships for training in other countries.

Assistance to newly independent states. In its penultimate session, the Assembly unanimously adopted a resolution concerning the granting of independence to colonial countries and people. Welcoming the attainment of independence by new states and their entry into WHO, and stressing that WHO has an important part to play in promoting the rights of colonial peoples to freedom and independence through assistance in raising levels of physical and mental health, the resolution appealed to the member states of WHO to introduce or develop in their health education programs the teaching of the principles of racial equality and non-discrimination, with a view to promoting good mental health and in recognition of the fundamental right of every human being to health.

Increase in membership. During the past year, thirteen newly independent African States joined WHO. At the beginning of 1960 there were 87 member countries and 3 associate members; there are now 106 member countries and 3 associate members. The Islamic Republic of Mauritania was admitted to membership and Tanganyika and Ruandi-Urandi were granted associate membership during the fourteenth assembly, and so the organization moves closer to its goal of universality of membership.

The increase in membership coincides in time with the increase of the executive board, the need for which was wisely seen by the twelfth assembly and which will come into effect this year, the number now being twenty-four.

Communicable diseases. One of the major goals to which the work of WHO is directed is the eradication of malaria; this tremendous campaign was launched in 1955. Up to date sixty-one countries or territories are fully engaged in malaria eradication work and another nineteen are on the point of adopting their final plan. Out of the total population of 1,336 million formerly exposed to malaria infection, 298 million or 22.3% are in areas where malaria has now been eradicated, while over 612 million or 45.9% are covered by malaria eradication programs. WHO is giving direct help, advisory services, fellowships and other means of training, supplies and equipment to the majority of countries engaged in this tremendous campaign.

During the assembly much time and thought was given to this field of work and one of the greatest problems confronting many countries was nomadism, as often population movements jeopardized the effectiveness of their programs. Therefore if eradication is to be successful there must be synchronization, co-ordination and co-operation between neighboring countries in carrying out malaria eradication programs.

The *financing* of this colossal program has become a most serious problem as it is found to be no longer possible to depend on financing operations on the existing basis. Up to date that part of the cost for which WHO is responsible has come from voluntary contributions to the Malaria Eradication Special Account, established in 1955. So far, however, the contributions have been inadequate and the fourteenth assembly was called upon to examine and decide upon other methods of financing WHO's share of the cost of the program.

The new scheme which was approved by the assembly is to transfer gradually, over a period of three years, the cost of field operations in the world-wide malaria eradication campaign from the special voluntary fund to WHO's regular budget. Efforts to obtain voluntary contributions to the special account from governments and private sources would continue. WHO's estimated share of the cost of the program for 1962 amounts to $5,498,904, According to the new scheme, around 2,600,000 dollars of this amount would, in 1962, be financed from WHO's regular budget. This new plan necessitates additional contributions from all member states to the Organization's regular budget, in accordance with the normal scale of assessment. However, to ease the burden on countries engaged in malaria eradication programs of their own, the new plan comprises a system of credits.

Tuberculosis. In the control of other communicable diseases, progress was also registered. Efforts to improve the diagnosis, treatment and prevention of tuberculosis were being continued. Results of comparative trials of domiciliary and institutional chemotherapy for tuberculosis, conducted by the Tuberculosis Chemotherapy Centre, Madras, with WHO's assistance, confirm that in suitable circumstances domiciliary chemotherapy is by no means inferior to institutional treatment. The two methods were found to be equally effective as regards improvement after one year of treatment, relapse rate during the second year and new cases among family contacts.

The subject of communicable diseases was discussed at length by the program and budget committee and though there had been some substantial achievements in combating parasitic diseases, WHO cannot hope to reach a satisfactory stage unless internationally co-ordinated research makes further important advances on these problems.

Virus diseases. The rapid progress in the study of live polio virus vaccines reported in 1959 was accelerated in 1960. The largest studies were in USSR where a strain developed in the United States was administered to fifty million people, with an impressive record of safety and strong indications of efficacy. A meeting of the WHO expert committee on poliomyelitis in 1960 decided that all strains of the orally administered vaccine had been shown to be safe for administration to children and thus safe for use where polio was predominantly a disease of childhood. In areas where polio affects a proportion of adults it was recommended that, for the time being at least, primary vaccination should be continued with the inactive vaccine and that oral vaccine should be reserved for the re-inforcement dose.

Environmental sanitation. WHO sanitary engineers and consultants visited countries in all six regions to promote programs for the improvement of community water supplies. Technical help was given to Peru on an important water supply project; a consultant in waterworks design helped the national authority in Cuba to expand safer water supplies rapidly; in Ghana a team of experts is helping with the development of the national water supply program and plans were made to help the Malagsy Republic to organize and execute a national water supply program.

Public health services. WHO is advising governments on the planning of public health services. The demand for nursing services, especially in the developing countries is continually increasing, and in 1960 WHO provided 163 nurses to 45 countries to help with nurse and midwife training, nursing administration, and as members of teams with public health programs and communicable disease control.

Education and training. During 1960 just over 1000 fellowships were awarded; the fellows came from 122 countries and territories and they studied in 83 different countries. The acute shortage of physicians and other fully trained personnel in the greater part of the world still imposes a high priority on training large numbers of auxiliary workers.

The fellowships program is of special benefit to the countries which have recently gained independence and

joined WHO; every effort is to be made to help countries adapt their medical curricula to modern conditions as well as to develop further the exchange of scientific information through seminars and conferences in a great variety of public health fields.

Radiation health. WHO is to assist countries in initiating or, where they already exist, in strengthening national services relating to the use of radiation and radioactive materials in health work; at the same time WHO will have the responsibility of co-ordinating internationally the research efforts which are being made in various countries in this entirely new domain. In this field WHO will work very closely with other international organizations.

The assembly urgently requested all members of WHO to prohibit all discharge of radioactive waste into watercourses for the sea, to the extent that the safety of such discharge has not been proved; and urged all health authorities of member states to take appropriate steps to train personnel in this field to accelerate their activities in public health aspects of radiation from all sources.

Budget for 1962. The assembly agreed that the effective working budget for 1962 shall be $23,607,180; this will be financed by assessments on members after deducting (a) the amount of $642,000 available by reimbursement from the special account of the expanded program of technical assistance and (b) the amount of $500,000 available as casual income for 1962.

A deduction of $203,000 was made by the director general from his original proposal, following the decision of the general assembly of the United Nations to reimburse WHO for the book value of its investment in the Palais de Nations, Geneva, WHO's present headquarters. A new headquarters for WHO is at present being built in Geneva.

WHO flag. The assembly also gave approval to a resolution that WHO should have a flag, and decided that the flag shall be the official emblem of the World Health Organization adopted by the first world health assembly, centered on a United Nations blue background, provided that the emblem shall appear in white with Aesculapian staff and serpent in gold.

It was decided that the fifteenth World Health assembly should be held in Switzerland; and invitations were received from the governments of Argentine and the Union of Soviet Socialist Republic to hold the sixteenth World Health assembly in 1963 in Buenos Aires and Moscow respectively.

Conclusion

The impressive program of work that has already been achieved and that is planned for the future is reflective of the wide vision of the Director General, Dr. Candau. Throughout the fourteenth World Health assembly country after country expressed their sincere appreciation to the director general, the deputy director general, the regional directors and to the whole of the secretariat for the assistance that had been given to their country and the work that was being carried out by the organization.

The program and budget adopted for 1962 attempts to preserve the continuity of WHO's evolution in recent years, with particular reference to the increasing importance of the stimulation and co-ordination of medical research, the continued need to concentrate efforts on the world wide eradication of malaria, the efforts to strengthen basic public health services, and the wish to accept fully the responsibility which a very substanstial increase in membership places upon the World Health Organization.

Respectfully submitted,
Dulcie G. Goode

REPORT ON CONFERENCE ON HOMEMAKER SERVICES

Lottie I. Barth, O.T.R.*

During 1961 I was privileged to attend two conferences on homemaker services, as a representative of the American Occupational Therapy Association. These meetings were the culmination of many national and local conferences that had been called by the National Health Council at the request of the executive committee of the National Conference on Homemaker Services. Fifty representatives of national voluntary health agencies were in attendance. In addition, selected resource persons from medicine, nursing, occupational therapy, medical social work, public health, physical therapy, government health agencies, hospitals, family and child welfare fields were invited to participate in these discussions.

Homemaker services are community services sponsored by public or voluntary health or welfare agencies which employ and train personnel to furnish assistance at home to families with children, to convalescents, the aged, the acute or chronically ill and persons disabled physically or mentally.

The purpose of the national conference was to focus attention on and stimulate the growth of homemaker services as an integral part of medical care. This can be done by community planning and participation of local agency affiliates who can help each community determine what auspices and what pattern of training would be best suited to the community's existing needs and resources.

The occupational therapist can make a contribution in the training of homemakers. It is the homemaker who very often helps the disabled housewife to function at home after her period of rehabilitation in a hospital or rehabilitation facility. The occupational therapist can help the homemaker understand that the only way to help the patient is to let the patient help herself. This is just one more area in which the occupational therapist can interpret his broad usefulness to the community and the health agencies with which he works. Included in the many concerns of the conference was what the training of a homemaker should include, as well as what limitations should be set on what she is allowed to do in the home, so that the family would know what to expect and the homemaker would have very definite areas in which she can function. This is most important to the occupational therapist because unless the homemaker does have an understanding of what the patient has been taught to do in terms of self-care and household activities, she can very easily undo all the occupational therapist's efforts in these areas. Therefore, the occupational therapist's importance as part of the training team cannot be overemphasized.

The homemaker services conference can be compared to the conferences on aging and on children which took place recently. Preparation involved about three and

*Executive Director, Occupational Therapy, Montefiore Hospital, Bronx, New York

a half years of exhaustive work and planning by the people and government agencies working on this project, therefore it is difficult to write a comprehensive report after attending only two meetings. Being a participant, even on this small scale, will help me plan a program to train homemakers at the hospital where I am employed. I hope this very brief summary might serve other therapists interested in the area. For anyone interested, the following resources may be of help.

1. *Homemaker Services.* Bulletins issued by the American Medical Association Council on Medical Service, 535 North Dearborn Street, Chicago 10, Illinois. Free.
2. *Homemaker Services—Twelve Descriptive Statements.* U. S. Dept. of Health, Education and Welfare. Available from the Superintendent of Documents, U. S. Govt. Printing Office, Washington, D. C. Price 55 cents.
3. *Homemaker Services in the United States—Report of the 1959 Conference.* U. S. Dept. of Health, Education and Welfare. Available from the Superintendent of Documents, U. S. Govt. Printing Office, Washington 25, D. C. Price $1.25.
4. *Homemaker Service—An Aid to Public Health Nursing.* Dept. of Public Health Nursing, National League for Nursing, 10 Columbus Circle, New York 19, New York. Free.

Psychological Tests . . .

(*Continued from Page* 204)

SUMMARY

Twenty-three emotionally disturbed mentally retarded boys aged eleven to fifteen were ranked by three different measures: Bender Gestalt maturation level scores, Wechsler performance quotient scores, and impressions of actual performance by an experienced occupational therapist who knew the boys very well. While the Wechsler and Bender scores were positively correlated with each other, the impressions of the therapist on actual performance were not positively related to either set of scores. The conclusion is that test scores alone are not sufficient for making a prediction about actual performance in occupational therapy. It is very probable that such factors as motivation and personal relationships with the therapist are of primary importance.

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3. Keller, J. E. "A Bender-Gestalt Maturation Level Scoring System." *Unpublished manuscript,* Wayne County Training School, 1958.
4. Edwards, A. L. *Statistical Methods for the Behavioral Sciences.* New York: Rinehart & Company, Inc., 1954.

DELEGATES DIVISION

CONNECTICUT

Delegate Reporter, Clyde Butz, O.T.R.

During the past year the members of the Connecticut Occupational Therapy Association have contributed a great deal toward "delegate business." Two of our general meetings were devoted to delegate business; one receiving AOTA information from the delegate and the second, members submitting their ideas, suggestions, etc., to the delegate prior to the annual conference.

There were five general meetings including a picnic. The eight international students from Yale University School of Public Health who had previously served as a panel for one of our meetings, and their guests, were invited to the picnic which was held in Hartford. The second meeting was held in Middleton and the House of Delegates agenda for the annual conference was discussed. The third meeting was held in Norwich when "Conference Highlights" and the House of Delegates meetings were presented in an informal manner. In order to keep all our active members informed of AOTA activities, each member receives a resume of the delegate's conference report in our state Newsletter.

Our fourth meeting was held in Hartford. Following a dinner we toured the Hartford Rehabilitation Center and then selected one of three coinciding "buzz sessions": 1. Pre-vocational with Psychiatric Patients, 2. Orthokinetics with the Physically Disabled and 3. Home Care and ADL.

Our fifth and annual meeting was held in conjunction with the Connecticut Medical Society meeting in Hamden, Connecticut. Dr. P. M. de la Vergne, Superintendent, Undercliff Hospital, Meriden, Connecticut, spoke on "New Approach to the Rehabilitation of the Chronic Mental Patient."

During the year we also had five executive board meetings, which are always well attended and stimulating.

Again this year we are striving to increase our membership. We compiled a listing of all the O.T.R.'s in Connecticut from the AOTA *Yearbook* and have been inviting all to attend our meetings and with personal contacts, we hope our efforts will be fruitful.

Our ways and means committee had a very successful year selling candy and calendars. Our recruitment chairman, Irene O'Brock, has resigned to assume similar duties on the national level. Her untiring service will be missed by all of us.

OFFICERS

President	Robert Belyea, O.T.R.
Vice-President	Louise Rothenberger, O.T.R.
Corresponding Secretary	Ruth Griffin, O.T.R.
Recording Secretary	Elizabeth Riley, O.T.R.
Treasurer	Jean Royal, O.T.R.
Delegate	Clyde Butz, O.T.R.
Alternate Delegate	Betty Clerc, O.T.R.

IOWA

Delegate Reporter, Mary Roose, O.T.R.

According to the Iowa Occupational Therapy Association constitution "the objects of the association shall be to promote the use of occupational therapy, to advance the standards of education and training in this field, to promote research, and to engage in any other activities that in the future may be considered advantageous to the profession and its members." About 50% of the occupational therapists in the state participated in some degree

in the association to consider and contribute to such activities.

Membership in the state association included 30 active members, 3 association members and 2 honorary members. Attendance at state meetings averaged 20 active members plus one associate member and several students. Three meetings were held in the past year: the November 6 meeting in Des Moines at Veterans' Hospital with Mrs. Maxine Virden, O.T.R., director of occupational therapy department, as hostess; the February 11 meeting in Iowa City at the Hospital-School for Severely Handicapped Children with Miss Helen Brom, O.T.R., director of occupational therapy department, as hostess; the May 6 meeting in Des Moines at the Vocational Training Center with Mr. Arthur Sundquist, O.T.R., director of the occupational therapy department, as host. Following the meetings three issues of the newsletter were published; in January, April and June of 1961.

One problem of the association is the scattered distribution of members with a concentration of 12 active members as well as students in Iowa City in southeastern Iowa. Another problem is the weather. The occurrence of unpredictable blizzards or ice from November through March can make meetings impossible during those five months. If the three summer vacation months are added, a total of eight months can be ruled out as being practical for assembling a quorum of active members.

To help in the solution of these problems the major business of the association this year was revision of the constitution to permit proxy ballots by mail, to require only two meetings per year, with one in the fall before the national conference and the other an annual meeting in April or May, and to decrease the quorum for elections from 2/3 of the active membership to a simple majority of resident active members. An optional meeting may be held in June as determined by vote each year and special meetings may be called by the executive committee or by majority vote of active members. These revisions were accepted readily and appreciation was expressed to the constitution revision committee composed of Miss Elsie McKibbin, O.T.R., chairman, Mrs. Rachel Doran, O.T.R., and Miss June Spieker, O.T.R., all of Des Moines.

Another subject of much discussion during the past year was recruitment. The fall meeting in Des Moines was devoted to methods and problems of public relations for occupational therapists. All members were asked to make direct contacts, to speak to groups and to utilize the services of communication facilities in each community. Members were also reminded that financing for recruitment activities will be the responsibility of each state association next year. Miss Jane Spieker, O.T.R., was an able vice-president and recruitment chairman this past year. A constitution revision changes the duties of that office to vice-president and public relations coordinator after July 1.

Two other therapists in the state gave notable service in public relations work for occupational therapy. Mrs. Jean Ehrenhaft, O.T.R., director of occupational therapy department at University Psychiatric Hospital, Iowa City, is recruitment chairman for the northern region which includes 13 states. Mrs. Judy Dorosin, O.T.R., University Hospital, Iowa City, participated as one of the rehabilitation team members on an "Expedition" production by KCRG-TV, Cedar Rapids.

A third accomplishment of the association was to assume the responsibility for sending the Iowa delegate to the national conference in Los Angeles. An assessment of $6.50 per active member was collected to cover the delegate's expenses. A project for the ways and means committee at present is to study the possibility of recommending an article of value to occupational therapists that could be resold by the members to provide income for future expenses of delegates and of public relations. An alternative possibility being considered is to increase annual dues by a substantial amount above the current $6.00 fee.

The February meeting was devoted to problems and procedures for work in geriatrics. A dynamic lecture by W. D. Paul, M.D., director of the University Rehabilitation Unit, preceded the movie, "Still Going Places." Mrs. Gyla Fairchild, O.T.R., director of occupational therapy, Veterans' Hospital, Iowa City, demonstrated an extensive display of ADL devices.

With competent officers and pertinent programs in 1960-1961 the Iowa Occupational Therapy Association informed active members about trends in public relations and geriatrics. The need for more professional responsibility from more therapists in the state was evident during the past year and may well be the goal for next year.

OFFICERS

President	Elizabeth Collins, O.T.R.
Vice-President	Jane Spieker, O.T.R.
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Newsletter Co-editors	Ellen Slusalek, O.T.R.
	Marla McCarty, O.T.R.

MISSOURI

Delegate-Reporter, Rose-Marie Finke, O.T.R.

Enthusiastic therapists and instructors have been working on recruitment programs during this past year.

A Girl Scout program jointly sponsored by the Washington University Occupational Therapy Department and the Missouri Occupational Therapy Association was highly successful. Thirty-eight Girl Scouts attended sessions on Saturdays conducted at the Washington University Occupational Therapy School, before being placed in hospital occupational therapy departments. The Health and Welfare Council has a part time paid worker to coordinate efforts of those recruiting in health careers. Brochures containing local and national fact sheets were distributed to all high school counselors in the area. A unit is being formulated in the junior high school curriculum in the State of Missouri and will be called "Health Science"; occupational therapy will be represented in this.

On June 9, 10, 11 the Missouri Occupational Therapy Association was host to the AOTA southern regional recruitment workshop. A stimulating and effective program was guided by Mrs. Francis L. Shuff, national recruitment chairman; Miss Julia Hardy, director of public information; Major Gertrude Murray, southern regional recruitment chairman; and Miss Theresa Burmeister, Missouri public relations coordinator. Eleven recruitment chairmen represented their state associations.

Monthly meetings and programs for forty-nine active, seven auxiliary, two associate and nine student members of AOTA were held with speakers from the medical professions as well as from our own group. Papers and discussions included "Attitudes Toward Mental Retardation," "Research on Use of Activity as Therapy for Teenagers in St. Louis State Hospital," "Highlights of 1961 AOTA Convention," "Hand Injuries," "Specific Uses of Occupational Therapy in Homemaking," "White House Conference on Aging."

Our Newsletter, *MOTivAtions*, has sparked reading interest with color sketchs, news, jokes, recipes, highlights of occupational therapy, etc. Our ways and means com-

mittee works with one goal in sight—1963 annual AOTA conference.

OFFICERS

President ..... Marion Stumpf, O.T.R.
Vice-President ..... Suzanne Hays, O.T.R.
Secretary ..... Alice Chadwock, O.T.R.
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NORTHERN CALIFORNIA

Delegate-Reporter, Elizabeth E. Holdeman, O.T.R.

The promoting of good public relations was one of Northern California's prime efforts during the past year. Our co-ordinator attended the Western Regional Recruitment Workshop in Seattle, where the vital issue arose of each state's part in future financing of recruitment programs. Our association sent representatives to several health organizations in the Bay Area and took an active part in the planning of the functional improvement program of the Bureau for Aid to the Totally Disabled. We held one of our meetings as part of the Western Hospitals convention and also participated as an exhibitor. "Career Kits" were constructed for distribution to the occupational therapy departments in selected hospitals where the therapists had received repeated requests for career information from visiting groups. The response to this new use of career materials has been gratifying. Membership this year totals 160, which includes 125 active; 10 active sustaining; 12 auxiliary; 3 associate; 10 student.

Eight general membership meetings were held, several of which were memorable: a reporting session by Marjorie Fish, executive director, and Virginia Kilburn, director of education, AOTA; an illuminating lecture on "A New Approach to Psychiatric Occupational Therapy" by Hassan Azima, M.D., and Fern Azima, M.A.; the panel presentation at the Association of Western Hospitals convention, "Occupational Therapy in the Rehabilitation and Home Care of the Severely Disabled" with Jose Montero, M.D., Edythe Larson, O.T.R., and Dorothy Rosenberg Montero, O.T.R.; and finally, at our annual meeting "Implications of Occupational Therapy in Current California Welfare and Rehabilitation Trends and Legislation" with two speakers from the state capitol, Leon Lefson, chief, Bureau for Aid to Needy Disabled, and Edward Rudin, department director, Community Mental Health Services.

This last meeting forced us to consider facts: that California is gaining rapidly in population, some indigenous, but a large part coming from other parts of the nation; that a significant portion of that population will require treatment; and that we, as members of a medically oriented group, must, like other rehabilitation organizations, find our place and fill it satisfactorily. We look forward to a year of real study of ourselves, of our professional function in the ever-broadening world of rehabilitation, and of more effective ways to promote concerted action by our membership.

OFFICERS

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Alternate Delegate ..... Eloise Eddy, O.T.R.

REVIEWS

INSTRUCTIONAL COURSE LECTURES, Volume XVII, Editor: Fred C. Reynolds, M.D., C. V. Mosby Co., St. Louis, 1960 PP. 421, $18.50.

"The 1960 Instructional Course Program of the American Academy of Orthopaedic Surgeons consisted of one hundred eleven separate courses. One hundred and fifty-six instructors participated in the program which was divided into 11 three-hour courses, 17 one-hour courses, and 83 two-hour courses. One thousand seven hundred and fifteen physicians registered for the entire program."

This volume contains material presented in approximately twenty-nine subjects on fractures, bone graft surgery, children's orthopaedics, athletic injuries and other miscellaneous subjects. It is a well-illustrated volume.

Although primarily written for the physician, describing actual surgical procedures, care and diagnosis, the therapist will find this book contains valuable information for anyone interested in orthopedics.

—Lester M. Brower, M.A., O.T.R., R.P.T

OCCUPATIONAL THERAPY IN REHABILITATION: A HANDBOOK FOR OCCUPATIONAL THERAPISTS, STUDENTS, AND OTHERS INTERESTED IN THIS ASPECT OF REABLEMENT. Edited by E. M. Macdonald, et. al. London: Bailliere, Tindell and Cox, 1960. Available in the United States from The Williams and Wilkins Company, Baltimore, Maryland. 337 pages, $8.50.

This volume, representing contributions from twenty-four therapists, gives an extremely broad coverage of occupational therapy in rehabilitation. The history of the profession, philosophy of treatment, types of media and techniques used, administrative procedures, patient evaluation and resettlement, and other subjects are discussed. Pertinent information on mechanics for occupational therapists, sample evaluation forms, and bibliographies are among the tables and condensed material found in the appendices.

Clearly defined therapeutic principles plus illustrative case histories and concise summaries of treatment make the chapters on treatment of patients with psychiatric conditions valuable. Although a similar pattern is followed, the presentation of the treatment of patients with physical, neurological, and systemic conditions is ambiguous and non-specific, frustrating the reader by pages of incomplete generalities.

Portions of the book are excellent; but on the whole it lacks unity and continuity and, in many respects, fails to fulfill the editors' stated purposes "to canalize ideas, to indicate clear aims, and to prevent diffusions of thought in what is, inevitably, a diffuse subject."

—Elizabeth Withers, O.T.R.

THE HEALING HEART. John Carlova with Ora Ruggles. Published by Julian Messner, Inc., $3.95.

Many occupational therapists will disapprove of this book because of the melodramatic treatment of hospital and patients. In *The Healing Heart*, Mr. Carlova has woven the life of a woman, the growth of a career and the development of a profession into a fast moving biography.

The story is carried forward by a series of conversations between Ora Ruggles, reconstruction aide and pioneer in occupational therapy and the many people she meets. The result is a picture of a dynamic, intelligent and charming woman who influences the lives of many but cannot always save a life.

Miss Ruggles started her career during the first world war in an amputee center at Ft. McPherson, Georgia. She moved on to a tuberculosis sanatorium in Arizona and then to Hawaii. She served the Army again in Los Angeles and finally started the occupational therapy department at The Children's Hospital in Los Angeles. Even in her retirement, Miss Ruggles finds that occupational therapy has important meaning in her life as she continues to apply the principles of occupational therapy in her daily living.

In the more formal and scientific atmosphere of modern hospitals, the occupational therapist seldom administers to the dying nor does he become involved with personal lives of patients. On the other hand, occupational therapists may take great pride in the skill and imagination of Miss Ruggles as she experimented with heart and hand in improving the physical and emotional conditions of patients. She takes advantage of a patient's interest in teaching by encouraging him to teach reading and writing to a group of illiterate patients; she used Tom Sawyer's techniques in persuading a hard-bitten group of tuberculosis patients to paint the floors of the tents in which they lived; and she uses the memory of a Japanese garden to encourage an old soldier to meet reality. Her attempts are not always successful but she always maintains her belief that "it is not enough to give a patient something to do with his hands. You must reach for the heart as well as the hands. It's the heart that really does the healing."

One might wish that Mr. Carlova had been more restrained in his description of hospitals and the benefits of occupational therapy, but he has told a tale that will be an inspiration to prospective therapists and remind the rest of us that people are still the most important product of the occupational therapist, that good interpersonal relations rely on the therapist's belief in the dignity of the human being, that activities are the tools of our trade and that they are limited only by our imagination and the needs of patients.

We may hope that this book may reach the hands of many high school students to picture for them the art of occupational therapy, if not the science.

—Mary D. Booth, O.T.R.

ROPE ROUNDUP, THE LORE AND CRAFT OF ROPE AND ROPING. Bill Severn. New York: David McKay Company, Inc., 1960, 237 pp. $3.95.

The first chapter of the book tells of the uses of rope and of the people who used rope through the ages. A later section tells of cowboy ropes and lariats.

The book recommends the type of rope to be chosen for different uses and tells clearly how to knot and tie.

Two separate chapters deal with tricky knots and puzzles and rope crafts and games.

The book would be of interest to many young patients and it might stimulate them to try the tricks and games.

—Eunice Ford, O.T.R.

TEACHING AIDS AND TOYS FOR HANDICAPPED CHILDREN. Barbara Dorward. Washington, D. C.: Council for Exceptional Children, National Educational Association, 1960, 31 pp., $1.50.

This manual is designed for the use of teachers and would be of interest to therapists who are working with physically handicapped and brain injured children. It describes and illustrates the construction and use of 26 teaching aids and toys. Each aid is adequately analyzed as to the purpose, method of use, description and modifications. The five areas included in the book are toys, shape and size perception, color matching, reading readiness and number readiness. There are practically no commercial items in any of the aids and toys and they may be made very economically.

—Jennie H. Knutson, O.T.R.

PLANNING HOMES FOR THE AGED. Geneva Mathiasen and Edward H. Noakes, Eds. New York: F. W. Dodge Corporation, 1959, $12.75, 113 pp.

An architectural study of homes for the aged. Planners might find the book of interest but arrangements for occupational therapy departments are superficial. If other areas are planned with equally poor forethought, the book would hardly be an adequate reference.

CHRONIC PHYSICAL ILLNESS AS THREAT. Franklin C. Shontz, Ph.D., Stephen L. Fink, Ph.D., Charles E. Hallenbeck. *Archives of Physical Medicine and Rehabilitation*, 41:4 (April) 1960.

The authors are concerned with the threat and effects of chronic illness upon the total structure of an individual, particularly upon the expressed importance of his physical body. Their study is based on the theory of psychobiological construction called "Total Structure" (which regards the human being as an organized composite which responds to both "inner" and "outer" forces and draws no rigid boundary around the person as a distinct physical entity.) It is theoretically stated that the chronic physically disabled individual is blocked by his disability from engaging in behaviors which are dependent upon the affected portions of his body. The illness may represent an active threat to the extent that the individual attempts to directly overcome it and sacrifices his higher-level development to this end. It may become a passive barrier when compensatory channels of expression are available. The theory is tested with a rated personal value scale designed to measure physical skills and capacities, and psychosocial objects and ideals.

Practical implications emphasize that personal values of the physically disabled are not always concerned with achieving complete physical cure even though these individuals do tend to be somewhat more concerned with physical functioning than do healthy persons. The study demonstrates that the basic balance of personal values between psychosocial and physical factors is only slightly disturbed by chronic physical illness. Most subjects consider it more important to be mentally healthy than to be physically healthy.

Other results indicate that frequently the problem behind refusal to accept medical care may be that personal values or the "self picture" of an individual may conflict with treatment goals. Other patients may find it more advantageous to be disabled, as disability may frequently serve the purpose of satisfying psychological needs.

—Lucille E. Viti, O.T.R.

HYSTERIA, REFLEX, AND INSTINCT. Ernst Kretschmer. New York: Philosophical Library, 1960, 162 pp., $4.75.

The subject is divided into two parts: "Hysteria, Instinct, and Drive"; and "The Psychophysical Dynamics of Hysteria." The work has been developed from clinical observations of cases related to World War I, and other findings including animal behavioral characteristics. It is also based on theories that have been presented by scientists such as Charcot, Freud, Hoche, Breuer and others associated with the fields of psychosomatic disorders and behavioral psychology.

Syndromes are described in terms of "ontogenetically determined patterns of reaction," "instinctive flurry," "the

death feint," "hypobulic reactions," "social hysterias (disability, war and accident neuroses)," and "endogenous hysterias (. . . deeply imbedded in the individual constitution)," and the "Ainu phenomenon." The latter topic pertains to studies made by Uchimura of conditions found among women inhabitants of a primitive race in northern Japan.

—Bertha J. Piper, O.T.R.

FUN WITH SHAPES IN SPACE. Toni Hughes. New York: E. P. Dutton & Co., Inc., 1960, 225 pp., $5.95.

A book full of decorations using kindergarten tricks to achieve designs for outer space. The many ideas in three-dimension construction will delight patients of all ages. The materials used are kitchen string, cardboard, sticks and other ordinary materials but the results are strictly for the 60's.

CEREBRAL PALSY AND RELATED DISORDERS. A Developmental Approach to Dysfunction. Eric Denhoff, M.D., and Isabel Pick Robinault, Ph.D. New York: McGraw-Hill Book Co., Inc., 1960, pp. 420, $12.00.

This book is compiled in a stimulating manner and offers a comprehensive and dynamic viewpoint. The authors, authorities in their own right, "believe that cerebral palsy is not a definitive entity in itself, but one aspect of a broader syndrome of cerebral dysfunction."

Cerebral dysfunction is neither fixed nor static. It is constantly changing. Workers must not only account for normal developmental growth, but must also account for the ever-changing picture cerebral dysfunction presents.

Chapters on medical diagnosis, prognosis and treatment should prove valuable to physicians. The sections in these chapters dealing with examination, electroencephalography and drugs are excellent. The physician and all the various therapists working in this field will be interested in the frank review and evaluation of the many known and used treatment philosophies and principles. Chapters dealing with sensory and perceptual disorders, the psychologic picture, the educational and community aspects, and young adults are tremendously worthwhile. Case histories illustrating the use of the developmental approach are included.

This book is especially for the physician and therapist with knowledge of the difficulties encountered in working with the youngster with cerebral dysfunction. It offers the reader a provoking philosophy. It is a significant contribution and the experienced therapist and physician should find it enlightening.

—Lester M. Brower, M.A., O.T.R., R.P.T.

PSYCHOLOGY AND EDUCATION. Selected Essays. Hirsch Lazaar Silverman, Ph.D. New York, N. Y.: Philosophical Library, 1961, 169 pp., $3.75.

The author impresses upon the reader that psychology is both an art and a science. "Through psychology there are many things to see in this world of men and events: new alignments, new problems, new vistas." Taken from Dr. Silverman's articles and essays which have appeared in professional journals, these selected papers contain highly thought-provoking and stimulating ideas. The "many things to see" appear as reflective surfaces from a kaleidoscope of human affairs.

Civil rights: "If our democratic way of life is to appeal to the peoples of the world everywhere, we must secure for all time our civil rights to all in the schools."

Psychiatric factors of delinquency: "Among the mental health needs in our school systems are improved services and facilities for diagnosis and treatment of the children who may in time become a community problem for whatever reasons; more information regarding techniques to prevent maladjustment to school interests; better in-service education programs to help teachers and other school personnel to foster better mental health; and the inclusion of mental health personnel as consultants to Boards of Education and to administrative staffs in school systems."

The relation of religion to psychology and to personality; the program of special education—the educable versus the trainable mentally handicapped children; psychology and philosophy; existentialism; and the psychology and psychiatry of Harry Stack Sullivan, are other topics discussed in the essays with illuminating interest.

—Bertha J. Piper, O.T.R.

FILMS FOR NURSING EDUCATION. Pennsylvania State University, Audio-Visual Aids Library. University Park, Pennsylvania, 1960, 33 pp., no charge.

This catalog lists films for rental and/or purchase, (only a few are free), gives prices, indicates type of audience for whom each is recommended, date and producer of film, and includes an adequate description of each one.

A large number of films are listed in the area of mental health, including considerable variety in patient problems and in methods of treatment. Many are restricted to professional audiences and appear to be both authoritative and technical in nature. The area of anatomy and physiology is similarly treated. Other areas represented include child growth and development, social and psychological phenomena, and public health problems.

This catalog should be of interest to those in both academic and clinical teaching programs and to therapists responsible for planning professional meetings.

—Carlotta Welles, M.A., O.T.R.

MANUAL OF CARE FOR THE DISABLED PATIENT. Arthur J. Heather, M.D. New York: Macmillan Co., 1960, 119 pp., $3.75.

This short text, by a physiatrist, touches on the early medical and nursing care which should be given to selected groups of the severely disabled. Included is the hemiplegic patient and his related gastro-intestinal and genito-urinary problems, plus those of decubitus ulcers and nutrition. Arthritis is similarly considered with an additional discussion of contractures and their prevention. Osteoporosis is touched on, and the manual concluded with a discussion of amputations and prostheses, but only from the medical and nursing viewpoint.

It is suggested that this elementary presentation of the medical aspects of these conditions should not be considered as adequate for any of the professional personnel who treat these patients. The discussions on medication are interesting, though may date the material, and are not very applicable to the role of the therapist. Rehabilitation, as it is usually thought of, is alluded to but not discussed, as this manual is primarily concerned with early care.

—Carlotta Welles, M.A., O.T.R.

THE DEVELOPMENT OF PHYSICAL THERAPY AS A PROFESSION THROUGH RESEARCH AND PUBLICATION. Catherine Worthingham, Ph.D. *The Physical Therapy Review*, 40:8 (August) 1960.

An analysis of the variances between technicians and professions. To be professional is to have a "body of knowledge and set of basic principles" acquired through research.

Included in the article is a discussion on research and publication as related to physical therapy but equally applicable to occupational therapy.

The University of Nebraska College of Medicine is starting a master's degree program this fall. They are in need of back issues of the *American Journal of Occupational Therapy for* 1948, 1949, 1950 and 1951. They would also like copies of *Occupational Therapy and Rehabilitation.*

If you have copies you no longer need and wish to have some one make use of them, contact H. Dwyer Dundon, O.T.R., Associate Professor, Nebraska Psychiatric Institute, 602 S. 44 Ave., Omaha 5, Nebraska.

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum ad $4.00 *for* 3 *lines, each additional line* $1.00. (*Average* 56 *spaces per line.) Classified display, boxed,* $5.00 *per column inch. Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

Help wanted female: OTR to head department in large private psychiatric hospital, 35 miles from New York City. Attractive salary. 5 day week. 4 weeks vacation. 7 holidays. Many fringe benefits. Write Box 15, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee 11, Wis.

Qualified occupational therapist for out-patient cerebral palsy treatment center. Starting salary $4750 per year. Two months vacation, liberal sick leave benefits, and liberal personnel policy. Contact Robert Schlitt, Director, Peninsula Cerebral Palsy Training Center, 901 24 Street, Newport News, Virginia.

Opportunity to organize complete activity program in newly constructed geriatric nursing service located near Indianapolis. Salary commensurate with experience. Many personal benefits. Contact Robert F. Oedham, Superintendent, Marion County Home, R.R. 10, Box 333, Indianapolis 19, Indiana.

DETROIT—CHIEF O.T.R. for OT section involved [illegible] training [illegible], functional referrals in GM [illegible] specific referrals from the psychiatric unit, and group prog[illegible] in pediatrics. Opportunity to orient interns, students and hospital personnel in the role performed by OT in the medical team. Administration considers this department vital to total patient care. Fully accredited, voluntary, non-profit, 340 bed hospital. Write Personnel Director, Detroit Memorial Hospital, 1420 St. Antoine, Detroit 26, Michigan, stating salary requirements

Immediate opening for therapist interested in initiating occupational therapy in an outpatient crippled children's clinic located on the border of Mexico and near lovely beach. One month vacation in summer and one week at Christmas. Salary open. Contact: George Odabashian, Pres. Brownsville Society for Crippled Children, Inc., Box 841, Brownsville, Texas.

Registered occupational therapist for large out-patient cerebral palsy clinic, thirty miles from New York City. Comprehensive services. Salary based on experience. Contact Miss Jean Eastman, 380 Washington Avenue, Roosevelt, L. I., N. Y.

Staff position—small private psychiatric hospital. Varied program includes sports and recreation. Modern facilities. No experience required. Salary depends upon qualifications. Write Mrs. Bunney, Chestnut Lodge, Rockville, Maryland.

APPLICATIONS CONTINUALLY ACCEPTED for staff therapists in rehabilitation hospital treating children and adults. Addition completed recently includes complete new OT department. Current staff of five is being gradually increased to meet greater in and outpatient capacity. Progressive personnel policies. Salary commensurate with experience and training. Location ideal for cultural interests and all sports. Further information and attractive brochure furnished on request. Apply to Administrator, Sunnyview Orthopaedic and Rehabilitation Center, Inc., 124 Rosa Road, Schenectady 8, New York.

Occupational therapist registered. Geriatrics and medical services. Start $4710. Annual merit increases to $5290. Liberal personnel policies. Apply Personnel, Grasslands Hospital, Valhalla, N. Y. LYric 2-8500 Ext. 61.

Opening for occupational therapist—full time—accredited private psychiatric hospital—70 bed. Located in Westport, Connecticut. (One hour from New York by train or car.) Write or call Hall-Brooke Hospital, Box 31, Greens Farms, Westport, Conn.

Staff position for registered occupational therapist or eligible graduate, rehabilitation dept. of large, modern tuberculosis hospital. Pleasant suburban location with good transportation, shopping and recreational facilities. 40 hour week, paid vacation and holidays, liberal cumulative sick leave, retirement plan. Full maintenance available at reasonable rate. Opportunities for further education in local universities. Write: Director of Rehabilitation, Sunny Acres Hospital, Cleveland 22, Ohio.

OCCUPATIONAL THERAPISTS for California's progressive programs in state mental hospitals and for physically handicapped children in special schools. Opportunities for imaginative and resourceful therapeutic activities. Eligibility for registration with the national registry of the American Occupational Therapy Association is required. No experience is needed to start at $436 a month. Positions in schools under the Crippled Children Services program are open also to experienced occupational therapists at $481 a month. Attractive employee benefits. Secure details from State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Immediate openings for one occupational therapy supervisor and two staff occupational therapists for adult and children's units, and one female staff therapist for adult and adolescent recreation services of progressive psychiatric center associated with University of Michigan Medical School. Four units of intensive treatment of children, adolescents and adults with occupational therapy supervisor on each unit. Student affiliation center. Generous personnel benefits; salary commensurate with experience. Address communications to Personnel Department, University of Michigan Medical Center, Ann Arbor, Michigan.

Hospital-school (residential): Staff position open for OTR in active, integrated program, functionally geared incorporating physical, social, emotional aspects of treatment. For information write Virginia Reeves, O.T.R., Supervising Therapist, Illinois Children's Hospital-School, 2551 N. Clark St., Chicago 14, Ill.

A progressive approach to occupational therapy as a psychiatric treatment, opportunity for education and professional growth. Openings for 2 occupational therapists, registered or eligible for registration, for staff positions in 61 bed psychiatric dept. of general hospital. Limited out-patient program. Pleasant surroundings, good working conditions. Write Personnel Department, Pres.-St. Luke's Hospital, 1753 W. Congress, Chicago 12, Illinois.

Wanted immediately—registered occupational therapist for out-patient center, single fund agency. Beginning salary $425 per month. Children and adults treated. Five-day week, good fringe benefits Staff also includes medical director, social worker, speech clinician and physical therapist. Write Pueblo Treatment Center, Inc., 1001 West St., Pueblo, Colo.

State OT consultant—under medical direction—to assist in the development of state-wide rehabilitation demonstration programs emphasizing good team care of elderly, handicapped people. Demonstration projects, probably of one or two years duration, will show what can be done for selected group of patients. OTR and 4 years of relevant professional experience. New salary range effective July 1, 1961: $6,912-$8,952. R. J. Siesen, Personnel Officer, State Board of Health, Madison 2, Wis.

Georgia Warm Springs Foundation

GRADUATE COURSE

Physical Therapy and Occupational Therapy

In the Care of *Neuro-Muscular Disease*

This course is open to graduates of approved schools of physical and occupational therapy. Such graduates must be members of the American Physical Therapy Association and/or American Registry of Physical Therapists, or American Occupational Therapy Association.

Entrance dates: First Monday in January, April and October.

Course I—Emphasis on care of convalescent neuromuscular disease with intensive training in functional anatomy, muscle testing, muscle reeducation and use of supportive and assistive apparatus. This course is complete in itself.

Course II—Three months duration with course I prerequisite. Emphasis on care of severe chronic physical handicaps with intensive training in resumption of functional activity and use of adaptive apparatus.

In-Service Training Program—Fifteen months duration at salary of $225 per month plus full maintenance, increasing to $250 per month at the completion of nine months. This program includes training in course I and II.

Tuition: None. Maintenance is $100 per month.

For further information contact:

ROBERT L. BENNETT, M.D.
Executive Director

Georgia Warm Springs Foundation
WARM SPRINGS, GEORGIA

Staff Occupational Therapist
Words like these apply to the special interest areas of the O.T. Department of Children's Hospital—

Broad Scope (General, Medical, Surgical, Pediatrics, Physical Disabilities).
Ward and Shop programs. In and out patients.
O.S.U. teaching affiliation.
Recreation program and playrooms.

For the position of Staff Occupational Therapist, we do not want the impossible—but we do want a person interested in further creative development of programs. Experience is preferred but not required. Apply at the Personnel Department, Children's Hospital, Columbus, Ohio.

A variety of experiences are available for ten more staff therapists in a chronic disease (all ages) and geriatric program in a 2000 bed city hospital and home affiliated with New York Medical College! Positions are available in adult rehabilitation, children's rehabilitation (cerebral palsy), volunteer and OT assistant program, home care, pre-vocational, adaptive equipment and woodworking (male therapist preferred), and special studies. We have nine OTR's and a student training program. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit, six hour day for summer months. Open salary. Write to Mrs. Carolyn Aggarwal, O.T.R., Chief of OT, Bird S. Coler Hospital and Home, Welfare Island, New York 17, New York.

New OT building—openings for junior and senior occupational therapists in large progressive state mental hospital located twenty miles west of Spokane, in the heart of the Inland Empire. Unlimited facilities available for imaginative and energetic person to participate in forming and planning of occupational therapy program to be inaugurated in the new $750,0000 building. Paid vacations and holidays, sick leave, annual leave, retirement plan, and annual salary increase. Apply Personnel Office, Eastern State Hospital, Medical Lake, Washington.

The Nebraska Psychiatric Institute is accepting applications for staff therapists working in progressive occupational therapy department. Excellent opportunity to gain experience working closely with graduate program offering masters degree in psychiatric occupational therapy. Contact Mr. H. Dwyer Dundon, OTR, Chief, Occupational Therapy, Nebraska Psychiatric Institute, 602 South 44th Avenue, Omaha 5, Nebraska.

Occupational therapist: vacancies exist in our physical medicine & rehabilitation service for 2 staff occupational therapists, GS-7, with salary range from $5355 to $6345. Facilities are modern with excellent opportunities for professional growth and advancement. Write or call Personnel Officer, VA Center, Dublin, Ga., for more detailed information.

Position available: staff OT (2) for 100 bed children's rehabilitation center. Excellent opportunity for professional growth: graduate education available. Fine working conditions and liberal benefits. Salary commensurate with experience. Inquire: T. P. Hipkens, Exec. Dir. Home for Crippled Children, 1426 Denniston Ave., Pittsburgh 17, Pa.

Director of occupational therapy department needed for the psychiatric research, training and treatment center of the N. C. Memorial Hospital of the University of North Carolina School of Medicine. Fifty-four bed inpatient unit, outpatient and child psychiatry sections with approximately 20,000 visits per year. The combination of a pleasant climate and a friendly atmosphere make this southeastern United States campus an ideal place to live and work. Compensation will be in the $4,632-$5,100 range. Minimum qualifications are graduation from a four year college or university with course work in occupational therapy and two years experience in this field. Please contact: John A. Ewing, M.D., Director of Inpatient Service, Psychiatric Center, N. C. Memorial Hospital, Chapel Hill, North Carolina.

Registered occupational therapist—for the Cerebral Palsy Center of Atlanta, Inc. Day school program, clinic and out patient services for 150 children ranging in age from 18 months to 18 years. Five day work week, public school holidays, 2 weeks summer vacation, and sick leave. Salary open. Send qualifications to Mrs. Harold M. Seymour, Administrator Cerebral Palsy Center of Atlanta, Inc., 1815 Ponce de Leon Avenue, N.E., Atlanta 7, Georgia.

Staff positions for registered occupational therapists, adult and children's services, both ward and clinic, small out-patient group, expanding rehabilitation program. Participation in interdisciplinary clinics; regular responsibilities in connection with the undergraduate OT curriculum and the student affiliation program of the department. Write Miss Patricia Laurencelle, OTR, Director, Program in Occupational Therapy, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

A challenging position available for experienced psychiatric OTR. Opportunity to develop activity therapy program on a newly opened treatment unit directed by one of the five medical schools affiliated with this institute. Extensive educational and research possibilities. Salary range $5,940 to $7,380, depending upon experience. Write: Mrs. Carolyn Owen, OTR, Activity Therapies Director, Illinois State Psychiatric Institute, 1601 W. Taylor St., Chicago, Ill.

Position available: Chief occupational therapist for challenging position in children's rehabilitation center. An excellent opportunity to utilize professional skills to fullest. Graduate education available. Good working conditions and liberal benefits salary commensurate with experience. Inquire: T. P. Hipkens, Exec. Dir. Home for Crippled Children, 1426 Denniston Ave., Pittsburgh 17, Pa.

Challenging opportunity for registered OT or eligible graduate in modern 450 bed general hospital with new 50 bed psychiatric unit. Expansion of OT program in physical disabilities, general medicine and surgery, and psychiatry necessitates hiring another therapist immediately! Excellent working conditions in completely new OT department, 40-hour week, paid vacation and holidays, sick leave, and insurance benefits. Apply to Dr. Ernest W. Johnson, Director of Physical Medicine, Mt. Carmel Hospital, 793 W. State, Columbus 22, Ohio.

Occupational therapy supervisor and occupational therapist for large active physical medicine and rehabilitation department in a general hospital under direction of a certified physiatrist. Approved active residency training program. Active inservice educational program. Liberal salary, group health and life insurance, retirement system, laundry and maintenance, three weeks vacation. For information write Personnel Officer, State of Connecticut, Veterans Home and Hospital, Rocky Hill, Connecticut.

Immediate opening for O.T.R. in a 400 bed general hospital located near world famous Carmel, Monterey and Pebble Beach areas. Salary range $4812-$5952 with three weeks vacation, sick leave, 11 or 12 paid holidays and an excellent optional health insurance plan. Write Personnel Dept., Monterey County Hospital, P. O. Box 1611, Salinas, California.

WANTED IMMEDIATELY: Qualified occupational therapist for a staff position in the Rehabilitation Center for the Crippled, Huntsville, Alabama. The department is well equipped and a growing center in a rapidly expanding city. The salary range is from $4500 to $6000 annually, and other benefits. If interested please contact Mr. L. O. Dees, Administrator, Rehabilitation Center for the Crippled, 316 Longwood Drive, Huntsville, Ala.

Occupational therapist, registered, for 100 bed children's orthopedic hospital. Exceptional opportunity for therapist to integrate active department into expanding program. Apply to Virginia C. Pruitt, Administrator, Kernan Hospital for Crippled Children, Baltimore 7, Maryland.

Staff occupational therapist position open in 140 bed hospital. Staff of five registered therapists. Interesting rehabilitation work with children and adults, all types of orthopedic cases. Nationally recognized amputee center with federal amputee research program. Excellent learning situation. Registered therapists do only functional therapy under direct supervision of orthopedic surgeons. Affiliate student training program. Salary commensurate with national standards. Three weeks vacation with pay and six legal holidays. Contact Miss Leila McNabb, O.T.R., Director, Occupational Therapy, Mary Free Bed Guild Children's Hospital, 920 Cherry St., S. E., Grand Rapids, Michigan.

Registered occupational therapist needed for Veterans Administration Center—570 bed GM&S hospital and 1,250 bed domiciliary. OT staff consists of five therapists and four OT assistants. Starting salary, recent graduate with little or no experience, $4345; experienced therapists, $5,355. Additional benefits: annual and sick leave, retirement system and insurance. The Center is located on historic Hampton Roads, Virginia, in the City of Hampton, close to Norfolk and Virginia Beach. For application forms or further information, write or call Personnel Division, VA Center, Kecoughtan, Virginia.

Immediate opening for a registered occupational therapist in psychiatric unit of the Barnes-Hospital-Washington University Medical Center. Modern teaching hospital. Apply to Miss Marion Stumpf, O.T.R., Director, Occupational Therapy, Renard Hospital, 600 So. Kingshighway, St. Louis, Mo.

Male or female registered occupational therapist wanted, 2000 bed psychiatric veterans hospital, Lyons, N. J. (near Plainfield, N.J.); career civil service; liberal benefits; salary $5355 to $6345. Chance for advancement. Write: Personnel, VA Hospital, Lyons, New Jersey.

OCCUPATIONAL THERAPISTS wanted in large psychiatric hospital located near Waukegan, Illinois, one hour to Chicago Loop. Starting salary $5355 per year. Meals and non-housekeeping quarters available. Benefits include liberal vacation and sick leave, generous health and life insurance, and an excellent retirement plan. Write: Chief, Personnel Division, Veterans Administration Hospital, Downey, Illinois.

Interesting opportunities in teaching and clinical research are opening at Milwaukee-Downer College for O.T.R.'s who have completed graduate work or who wish to start graduate study with employment. Address inquiry to Miss Henrietta McNary, O.T.R., Milwaukee-Downer College, 2512 E. Hartford Ave., Milwaukee 11, Wis.

Position available Jan. 1, 1962. Additional staff pediatric O.T.R. for new 130-bed unit. Integrated team program. View of mountains, winter sports. Salary dependent upon experience. Miss Miriam Scanlan, O.T.R., Chief, Occupational Therapy, National Jewish Hospital at Denver, 3800 E. Colfax Avenue, Denver 6, Colorado.

Immediate opening for occupational therapist (experience desirable) in 355 bed university general teaching hospital. Newly remodeled and equipped department with growing program. Student training center. Attractive salary and benefits including educational opportunity. Apply: Mr. Edwin L. Taylor, Director, The Graduate Hospital of the University of Pennsylvania, Philadelphia 46, Pa.

WANTED: Experienced, qualified person to direct activities therapy department of new expanding psychoanalytically oriented private psychiatric hospital and day hospital. Active in-service education, multi-discipline staff, student affiliation in recreational therapy and nursing. Interested in developing OT affiliations. In residential area, near UCLA. Wide range of profesisonal, educational, and cultural opportunities within the community. Salary open. For information or to apply, write: Ruth Barnard, M.D., Clinical Director, The Westwood, 2112 S. Barrington, Los Angeles 25, California.

Opening for O.T.R. interested in helping develop an active treatment program for geriatric and long term patients. Opportunity for professional development. CS benefits, salary $4800-$5760, full maintenance available. Hospital within walking distance of downtown. Write Mr. Miller, O.T.R., Oregon State Hospital, Salem, Oregon.

Opening immediately for registered occupational therapist interested in psychiatry. Diagnostic and acute treatment service with a bed capacity of about 70 patients, small occupational therapy unit within the department. Therapists should have the ability to independently plan and carry out occupational therapy program under the direction of the physicians.

For further information write Miss Judy Harris, O.T.R., Dept. of Physical Medicine and Rehabilitation, Marion County General Hospital, 960 Locke Street, Indianapolis 7, Indiana.

O.T.R. needed for vacancy in a comprehensive rehabilitation, out-patient center. Experience not necessary, excellent fringe benefits available, salary commensurate with experience. Only those therapists capable of working in a closely knit rehabilitation center need apply to E. D. Jordan, O.T.R., Executive Director of the Southwest Louisiana Rehabilitation Center, Box 2705, Lafayette, Louisiana.

Opening for occupational therapist in a growing program for tuberculosis patients. Five day week, paid vacation plus 10 paid holidays, sick leave. University city with excellent shopping and theatres available. Salary open. Live-in facilities. Apply: Personnel Dept., Benjamin Franklin Hospital, 1755 Alum Creek Drive, Columbus 7, Ohio.

OCCUPATIONAL THERAPIST. Staff position available in 1600 bed general medical surgical hospital: expanding occupational therapy department includes GM and S, orthopedic and neurological disabilities, cerebral palsy and new comprehensive rehabilitation unit. Active student training program. Salary starts at $4420 depending on experience; 37½ hour work week, 4 weeks' vacation, liberal personnel benefits. Please contact Personnel Office, Presbyterian Hospital, 622 West 168 Street, New York 32, N. Y.

OT to head dept. of rehabilitation center. Presents challenge of multi-purpose program. Also provide consultation to community health groups. Forty hour, five day week; three week vacation. Salary based on experience. Write Dir. Curative Workshop, 342 S. Webster, Green Bay, Wis.

DIRECTOR—modern hospital treating tuberculosis and allied pulmonary diseases. Occupational therapy and nurse affiliation programs. Patient rehabilitation conferences with heads of professional services. Complete cooperation of the medical staff. Close liaison with active state rehabilitation program. Five-day, 40-hour week, paid vacation, seven holidays, sick leave, social security. Excellent opportunity for progressive middle aged administrator.

Send resume to W. C. Anderson, Executive Director, Emily P. Bissell Hospital, 3000 Newport Gap Pike, Wilmington 8, Delaware.

Progressive 1600 bed state hospital has three openings for either trained or registry eligible occupational therapists. Beginning salary $395 a month. Administration is occupational therapy orientated and chances and opportunities for professional growth are unlimited. Hospital is located on large lake and offers many cultural and recreational facilities. Fringe benefits include one free meal, free uniform laundry, liberal retirement and medical benefits program. Write to: Kenneth Overly, O.T.R., Director of Occupational Therapy, Kentucky State Hospital, Danville, Kentucky.

One replacement and one new faculty position in the curriculum in occupational therapy at the University of Washington, offer opportunity for both teaching and research in expanding new rehabilitation center. Address inquiries to Division of Occupational Therapy, Department of Physical Medicine and Rehabilitation, University of Washington, Seattle 5, Washington.

Formal application should include curriculum vitae, references and titles of papers published.

WANTED: OCCUPATIONAL THERAPIST seeking a stimulating environment for professional growth, exper. and educational opportunity. Medically supervised occupational therapy programs in neurological, orthopedic, pediatric, chest medical, geriatric, and psychiatric areas. Location is ideal for cultural and educational interests. Sal. $4,004-$6,192. Civil service benefits. Apply to Mrs. Lucyann R. Martin, O.T.R., Occupational Therapy Instructor, Box 361, Los Angeles County General Hospital, 1200 N. State Street, Los Angeles 33, California.

Occupational therapist for a convalescent hospital (adults and children). Liberal benefits, top salary, may live in for $13.00 We.—room and board. St. Luke's Convalescent Hospital, King Street, Greenwich, Conn.

REGISTERED OCCUPATIONAL THERAPIST. Permanent full-time work; 31 psychiatric bed unit in a 500-bed general hospital. Contact: Personnel Office, Toledo Hospital, 2142 No. Cove Blvd., Toledo, Ohio.

Staff therapist in private 200 bed psychiatric hospital 23 miles north of New York City. Expanding program in newly opened building. Rural setting. Maintenance available if desired. Three week vacation first year, four weeks thereafter. Salary open. Contact Jane Reuter, O.T.R., St. Vincent's Hospital, Harrison, New York.

Director and staff—for expanding occupational therapy departments. Complete program for children and adults. Full information on request. Write: Medical Director, Crotched Mountain Rehabilitation Center, Greenfield, New Hampshire.

OCCUPATIONAL THERAPIST—graduate of OT accredited school. Forty-hour week. Permanent. For apppointment call New Jersey Orthopaedic Hospital, ORange 5-1100, Ext. 455.

OCCUPATIONAL THERAPIST for newly created department in psychiatric division of progressive teaching hospital. Modern facilities available within 28 bed psychiatric unit. Inquire: Mount Sinai Hospital, Director of Personnel, 2750 W. 15 Place, Chicago 8, Illinois.

Immediate position for registered occupational therapist in new Easter Seal supported rehabilitation center. Well equipped out-patient treatment center for physically disabled children and adults. Staff therapist to do individual functional therapy and pre-vocational evaluations. QUALIFICATIONS: experience in cerebral palsy and physical disabilities. SALARY: Commensurate with qualifications and experience. CONTACT: Mrs. Monica Baird, Acting Executive Director, Samuel Gompers Memorial Rehabilitation Center, 7211 North 7 Street, Phoenix, Arizona.

OCCUPATIONAL THERAPIST, REGISTERED, for modern 221 bed hospital in rural area. U. S. citizen. Salary range $392.00/$491.00. With experience, starting salary second step ($415.00), outstanding qualifications at third step ($439.00). Retirement system, including social security. Write to Tulare-Kings Counties Hospital, Springville, California.

OCCUPATIONAL THERAPIST

College graduate—registered or eligible for registration. 5,000 bed AMA accredited state mental hospital in beautiful northern N. J. within an easy hour of NYC. Well OT oriented, progressive administration. Salary range $4,750-$6,178 for staff OT; $5,237-$6,809 for Sr. Fine civil service system with liberal paid vacations, holidays and sick leave benefits. Social security and state pension with free life insurance, also free Blue Cross expected Oct. 1. Low cost maintenance available. Write Richard E. Winans, Personnel Director, New Jersey State Hospital, Greystone Park, N. J. (near Morristown).

OCCUPATIONAL THERAPIST—immediate opening for work with multiple handicapped children. Program includes all therapies and services. For details, contact Director, West River Hospital-School, Hot Springs, South Dakota.

Registered occupational therapist wanted for position in small, private psychiatric institution whose treatment program is directed toward acute illnesses only. Broad program of activities, pleasant working conditions. Located in a city with many cultural and educational advantages. Write to: Miss Muriel Raum, Director OT and RT, The Seton Psychiatric Institute, 6420 Reistertown Rd., Baltimore 15, Maryland.

Staff position for registered occupational therapist in community rehabilitation center offering comprehensive services. Opportunity for working with a wide variety of physical disabilities in all age groups. Salary commensurate with experience. Write Robert A. Silvanik, Administrator, Rehabilitation Center of Summit County, 326 Locust Street, Akron 2, Ohio.

Wanted: staff OTR with one year experience to assist with work in large general hospital. Paid vacation, sick leave, salary open. Apply Head of Personnel, Saint Luke's Hospital, 11311 Shaker Boulevard, Cleveland 4, Ohio.

Director of occupational therapy department—220 bed expanding pediatric hospital. Modern, progressive program; activities at bedside and in OT dept.; physical and emotional disabilities. Applicant should have had recent supervisory and administrative experience. Salary dependent on experience and qualifications. Liberal benefits. Write to Richard E. Eyestone, Personnel Director, Children's Memorial Hospital, 707 Fullerton, Chicago 14, Illinois.

QUALIFIED OCCUPATIONAL THERAPIST—assistant—required immediately for this small psychiatric unit (235 beds). Establishment of two. A new department is planned to replace existing attractive small department. The successful applicant will be required to help in the planning of a new and expansive remedial and industrial program. The hospital is within daily traveling distance of Edinburgh, but pleasant residential accommodation available if required. Applications, stating age, qualifications and experience should be sent to Group Secretary and Treasurer, Board of Management for East Lothian Hospitals, 31 Court Street, Haddington, East Lothian, Scotland.

OCCUPATIONAL THERAPIST needed by the Pennsylvania State Health Department to work in a tuberculosis sanatorium located at South Mountain, Pennsylvania. Requires graduation from an approved school of occupational therapy. Salary range $4,773-$6,390. Liberal personnel policies with excellent retirement plan. For further information or applications, please write Mr. Andrew L. McCabe, Personnel Director, Pennsylvania Department of Health, P. O. Box 90, Harrisburg, Pennsylvania.

Pre-vocational unit—out-patient rehabilitation setting offers challenging and diversified opportunity in work evaluation and work adjustment program for individuals with residual orthopedic, neurological and emotional disabilities, and mental retardation. Center facilities include the restorative therapies, pre-vocational services, vocational counseling, social service, psychological testing, two sheltered work shops and liaison with neighboring hospital for job trials. Experienced therapist preferred but not essential; personal interview required. Salary commensurate with experience. Contact Miss Clari Bare, O.T.R., Hartford Rehabilitation Center, Inc., 2 Holcomb Street, Hartford, Connecticut.

Immediate openings for two registered occupational therapists. Experience required for one position. Full rehabilitation program for all types of physical disabilities under supervision of three full-time physiatrists. Both in and out-patient services offered. Beginning salary dependent upon experience or $4,800 per year with no experience. Three weeks vacation per year, sick leave, life and health insurance programs, and free laundry of uniforms. Contact Director, Institute of Physical Medicine and Rehabilitation, 619 N.E. Glen Oak Avenue, Peoria, Illinois.

Staff position available in 600 bed teaching hospital. Located in scenic surrounding and within easy driving distance of coast and metropolitan areas. Liberal personnel policies. Contact: Personnel Office, University of Virginia, 1416 W. Main St., Charlottsville, Va.

Position available for staff therapist in physical disability clinic of a university hospital. Write: Mrs. Mary K. Bailey, Chief Occupational Therapist, The Johns Hopkins Hospital, Baltimore 5, Maryland.

Are you as a registered occupational therapist interested in being a part of a dynamic program in a progressive psychiatric hospital where the most modern psychiatric thinking is applied in the treatment of the patients? The occupational therapy department offers professional growth with a challenging program in just such a hospital. Colorado State Hospital has need of staff therapists and a senior therapist. Salary range for staff therapist is $4860 to $6204; for senior therapist, $5364 to $6840. For further information write Mrs. A. Ward Lockhart, O.T.R., Director of Occupational Therapy, Colorado State Hospital, Pueblo, Colorado.

STAFF OCCUPATIONAL THERAPIST: Position available. Salary range $4,325-$4,975 depending on experience. Merit increases. 37½ hr. week, vacations, holidays, sick leave. Well equipped dept. including prevocational evaluation, affiliated with Northwestern Medical School. OT student training program. Comprehensive rehabilitation program for physically disabled in and out-patients. 70 bed hospital. Congenial atmosphere, excellent opportunity for personal development. Should be graduate of approved school of OT and hold membership in AOTA or Registry. Contact Mr. Clark Sabine, O.T.R., Rehabilitation Institute of Chicago, 401 E. Ohio St., Chicago 11, Ill.

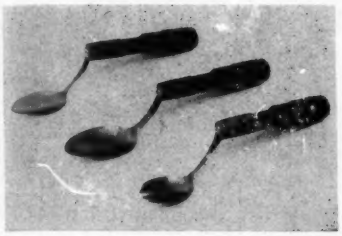
REGISTERED OCCUPATIONAL THERAPIST South Florida Gold Coast. Year around resort living. Student affiliation and research center. Diagnostic evaluation and intensive treatment program. State and social security retirement benefits. Paid vacations, holidays and hospitalization plan. Salary $4400.00/annum. Apply Director of Personnel, South Florida State Hospital, Hollywood, Florida.

WANTED: OCCUPATIONAL THERAPIST as director of department for continuation and expansion of program. At present plays important role in general rehabilitation program and is correlated with other hospital departments. Calls for imagination and initiative in trying new approaches. Hospital located in heart of Green Mountains close to several large ski developments, 135 miles from Montreal, 200 miles from Boston. Associated with College of Medicine. Beginning salary $4446.00, advances by scheduled increments to $5746.00. Living accommodations available at modest cost. Liberal vacation, sick time allowances. Retirement program. Write—R. A. Chittick, M.D., Superintendent, Vermont State Hospital, Waterbury, Vermont.

OCCUPATIONAL THERAPIST for duties in State Crippled Children's Service, merit system, retirement benefits, liberal vacation and sick leave. Salary: Occupational Therapist I without experience, $4,680; Occupational Therapist II with experience, $5,220-$5,940. Write to Director, Crippled Children's Service, State Board of Health, Dover, Delaware.

Needed: two registered therapists. A progressive rehabilitation center, in and out patients, full team, educational and dynamic OT program stressing functional therapy, ADL training, home-making, pre-vocational and blind training. Located 25 miles from New York City. Starting salary open, with excellent benefits. Positions now open. Contact Miss Joan Caspersen, O.T.R., Supervisor, OT Dept., Burke Foundation Rehabilitation Center, Mamaroneck Ave., White Plains, New York.

Have You Tried?



A group of newly designed eating utensils answers the demand for an adult-sized set which allows many patients with limited hand or arm function to feed themselves. The swivel action of the bowls on long-wearing nylon bearings, keeps them level even when the user's wrist or arm is unsteady. This prevents spilling of foods and brings new confidence in eating.

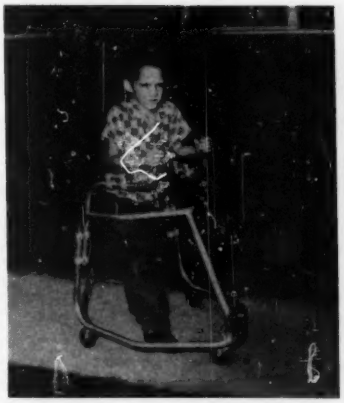
The specially designed grip on the (4½") plastic handles is also a boon to those with limited hand function. It can be held in either right or left hand with relative ease. The utensils wash as other flatware, even in commercial dishwashers. Three pieces are available: a teaspoon at $2.00, soup spoon at $2.50, and spork (combination spoon and fork) at $3.00 or the 3-piece set at $7.20 from Fascole Corporation, 257 Park Avenue South, N.Y.C.

DISPOSABLE SOAP DISHES designed as an answer to cross-contamination originating from multi-use soap dishes are available from Rehabilitation Products, a division of American Hospital Supply Co., Evanston, Illinois. The dishes cost little, may be incinerated and are impervious to soap and moisture.

Because they are inexpensive they could be utilized as convenient and disposable paint dishes in occupational therapy departments.

* * *

THE GOLKA TIPPING PLIERS have gained widespread acceptance among occupational therapists. For the few not acquainted with them, the pliers apply tips to leather laces for easy lacing. The grip of the tip prevents it from sliding off even plastic laces and the tip is satisfactory for both round holes or slits. The pliers sell for $2.50 and 160 disposal tips are sold for 25 cents, and both are available from Robert J. Golka Company, 400 Warren Ave., Brockton, Massachusetts. Send for a sample of a tipped lace and at the same time request a catalog, free of charge.



A new line of walking aids, designed for use in the rehabilitation of patients with lower extremity difficulties, has been announced by a Tulsa, Oklahoma, firm. Called WALK-A-GAIN WALKING AIDS, the new walkers are made of aluminum and are lightweight and rustproof.

Built on a triangular base with a swivel, ball-bearing front caster, and aligned non-swivel rear casters, the Walk-A-Gain has a low center of gravity and offers a further safety feature of a special out-rigger which prevents tipping.

The walkers are made in three sizes, for small children through adults, and in two models, the elbow-support type and a cane type for patients who need only a minimum support.

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